Evaluating the Effectiveness of Managing Powerful Emotions Skills Training for Adults with Mental Health Issues

by

Meagan Kitts

A thesis submitted to the School of Community Services in partial fulfillment of the requirements for the degree of Bachelor of Applied Arts in Behavioural Psychology

St. Lawrence College
Kingston, Ontario
Canada.
April, 2011
# Table of Contents

Dedication ........................................................................................................................ iv  
Abstract ............................................................................................................................ v  
Acknowledgement ................................................................................................................. v  
List of Tables and Figures ...................................................................................................... vii  
Chapter I: Introduction ....................................................................................................... 1  
Chapter II: Literature Review ............................................................................................ 3  
  Emotion Dysregulation ........................................................................................................ 3  
  Emotion Regulation ........................................................................................................... 4  
  Dialectical Behaviour Therapy .......................................................................................... 5  
  Emotion Regulation Training ........................................................................................... 5  
  Emotion Regulation & Mental Health Issues ..................................................................... 8  
Chapter III: Method .......................................................................................................... 10  
  Participants ....................................................................................................................... 10  
  Design ............................................................................................................................... 10  
  Setting/Materials ............................................................................................................... 11  
  Measures ........................................................................................................................... 11  
  Procedures ......................................................................................................................... 12  
Chapter IV: Results .......................................................................................................... 14  
Chapter V: Discussion ....................................................................................................... 18  
  Relationship to the Current Literature .......................................................................... 18  
  Strengths and Limitations ............................................................................................... 18  
  Multilevel Challenges ..................................................................................................... 19  
  Implication for the Behavioural Psychology Field .......................................................... 20  
  Recommendations for Future Research .......................................................................... 20  
Appendix A: Agency Informed Consent Sheet ................................................................... 24  
Appendix B: Consent Form ................................................................................................. 25  
Appendix C: Managing Powerful Emotions Course Outline .............................................. 29  
Appendix D: Emotion Regulation Homework Sheet ........................................................... 30
Appendix E: MPE Community Group Assessment................................................................. 32
Appendix F: Difficulties in Emotion Regulation Scale (DERS) ........................................... 33
Appendix G: Emotion Regulation Training Satisfaction Survey ........................................ 35
Appendix H: Raw Data........................................................................................................ 36
Dedication

I would like to dedicate my thesis primarily to my family who have loved and supported me throughout my life and academic journey. I would also like to dedicate this work to my friends whom without their support, I could not have succeeded in the Behavioural Psychology program. Thank you all so very much.
According to Gupta, Rosenthal, Mancini, Cheavens, and Lynch (2008) emotion dysregulation is a common symptom in a wide range of psychopathological issues, and is not simply specific to Axis I and II disorders. Emotion regulation training (ERT) may be helpful in the treatment of a wide array of mental health issues. ERT helps clients to become aware of and to accept their emotions, to perform trained adaptive behaviours, and to refrain from engaging in impulsive behaviours (e.g., self-harm) while experiencing negative emotions (Gratz, Rosenthal, Tull, Lejuez, & Gunderson, 2006). In this study, it was hypothesized that emotion regulation skills training would increase clients’ abilities to perceive, modify, and understand emotions, as well as increase the abilities to accept negative emotions as a part of their everyday lives. Seven individuals participated; five females, and two males. Participant ages ranged from 21 to 58 years ($M = 41, SD = 12.38$).

This study utilized a repeated measures design. The Managing Powerful Emotions (MPE) Community Group Assessment and the Difficulties in Emotion Regulation Scale (DERS) were administered at pre- and post- treatment. A client satisfaction survey was administered after the final training session. The intervention consisted of 10 weekly two-hour sessions. The content covered during the sessions included mindfulness, emotional awareness, emotion dysregulation, function of emotions, building positive experiences, acting opposite, cognitive distortions, and empathy. Homework completion was also recorded. A nonparametric Wilcoxon test was used to compare the mean differences within the treatment for the pre- and post- scores on the DERS. The Wilcoxon test was used to analyze the DERS data for the seven participants. This analysis showed a significant difference between emotion regulation skills level at post-treatment as compared to pre-treatment (Wilcoxon, $n = 7, z = -2.366$, two-tailed $p = 0.018$). The results support the hypothesis that participants would show an increase in total scores on the questionnaires from pre- to post- treatment. A Pearson correlation found no relationship between amount of homework done and overall results. In brief, participants reported that their skills improved in many areas of emotion regulation, which is promising. Overall, participants reported being satisfied with the treatment. Limitations of the study are discussed and focus on the following aspects: the small sample size, time-limited intervention, and minimal individualized training.
Acknowledgement

There are so many individuals who have helped me through this journey and I could never have done it alone. I would firstly like to acknowledge my parents, Randy and Cindy. You have helped me pave my path in the world with unconditional love and support; I could not have done this without you. I would also like to thank my other quarters in the program: Sarah, Erika, and Tiffany. We have been supporting each other through every step of this journey, and I would not have had it any other way. Thank you so much for your amazing friendship; you are a great part of what made these four years fantastic. I would like to thank my fourth year placement site and supervisors; without your support and expertise, I could never have completed this thesis. I would also like to thank Marie-Line Jobin, my thesis supervisor, for her endless and kind help, support, and expertise throughout this long journey. I would like to thank the faculty for guiding us all through this journey with your brilliant minds, and more importantly, hearts.
List of Tables and Figures

Figure 1. MPE Community Group Assessment Pre and Post Average Group Response .......... 14
Figure 2. DERS Pre and Post Average Group Response ............................................. 15
Figure 3. MPE Community Group Assessment Average Pre and Post Participant Responses .. 16
Figure 4. DERS Average Pre and Post Participant Responses........................................ 17

Table 1. MPE Community Group Assessment and DERS Average Pre and Post Group Responses............................................................................................................ 14
Table 2. Managing Powerful Emotions Community Group Assessment and Difficulties in Emotion Regulation Scale Pre and Post Average Participant Responses......................... 16
Table 3. Participant Homework Completion .................................................................... 17
Chapter I: Introduction

“The ability to deal effectively with negative emotions is widely thought to be integral to mental health” (Berking, Orth, Wupperman, Meier, & Caspar, 2008, p. 485). According to Gupta, Rosenthal, Mancini, Cheavens, and Lynch (2008), emotion dysregulation is a common symptom in a wide range of psychopathological issues, and not simply specific to Axis I and II disorders. A person displaying a deficiency in the ability to regulate emotions may have difficulties perceiving emotions, understanding emotions, and modifying emotions. The person may also show inability in accepting negative emotions. Gupta et al. (2008) also state that emotion dysregulation may be demonstrated by a difficulty in awareness, discrimination, and tolerance of emotional states, cognitions and sensations that are internal to the individual.

“Emotion dysregulation, however, can be defined not as an absence of regulation but as the use of inflexible strategies that may have served a specific function, but now interfere with social, cognitive or interpersonal functioning” (Livingstone, Harper, Gillanders, 2009, p. 420). The use of these inflexible strategies often leads to increased negative affect, which can lead to increased mental health issues (Berking et al., 2008). Livingstone et al. (2009) discuss the idea that once emotion dysregulation, characterized by social and cognitive dysfunction, becomes a stable characteristic within the individual; it increases their vulnerability to a plethora of psychopathological disorders. Similarly, Vasilev, Crowell, Beauchaine, Mead and Gatzke-Kopp (2009) spoke to the common characteristics that internalizing, externalizing, and comorbid psychopathologies all have emotion dysregulation at their core.

Emotion regulation is a developmental task that is rooted in infancy (Livingstone et al., 2009). It is a skill not often mastered until individuals are in early adulthood. This is evident by studying the stage of adolescence and its very common characteristic of emotion dysregulation. It is important to view emotion regulation with environmental roots, in addition to the physiological aspects. The environment plays a large role in the development of emotion regulation skills, and many other self-regulation strategies (Cole, & Deater-Deckard, 2007).

“Thus, chronic neglect and rejection influences the development of psychopathology in children, in part through its impact on psychological and physiological systems of regulation” (Cole, & Deater-Deckard, 2007, p. 1328). As many psychopathological issues often present with a history of childhood abuse and/or neglect and rejection, it is possible that emotion dysregulation is present in a wide array of mental health issues.

According to Gupta et al. (2008), eating disorders often present with symptoms of negative emotionality, in addition to the presence of ineffective eating behaviours. These negative emotions can often present as chronic feelings of shame that seem unmanageable to the individual experiencing them. Also, as stated by Mennin (2004), generalized anxiety disorder is often characterized by the inability to label one’s own emotions, accept them, and communicate and regulate these emotions. In addition, Livingstone et al. (2009) reported that mood disturbance and emotion dysregulation often closely predates psychotic symptoms. Therefore, emotion regulation training may be beneficial to many individuals with varying mental health issues in many populations. “Individuals for whom emotional regulation is particularly difficult may benefit from a therapeutic approach that places emotional functioning and the development of emotion regulation skills as its core” (Livingstone et al., 2009, p. 427).
According to Gratz, Rosenthal, Tull, Lejuez and Gunderson (2006), emotion regulation training is a complex construct that involves helping clients be aware more and accept all emotional responses, performing trained adaptive behaviours when experiencing negative emotions, and refraining from displaying impulsive behaviours (e.g. self-harm) while experiencing negative emotions. Emotion regulation is one of the four skills training modules in Dialectical Behaviour Therapy (DBT). For the purpose of this research, emotion regulation training will work from the DBT framework. As part of emotion regulation training, the client learns to use situationally appropriate strategies in order to modify the intensity or duration of emotional responses, as well as to withstand and deal with negative emotions as a part of their everyday lives.

Though there is literature suggesting that emotion regulation training is effective in treating mental health issues, it requires more research. This study will contribute to the already existing literature in assessing the effectiveness of emotion regulation training for the treatment of emotion dysregulation. This will be done by evaluating an emotion regulation skills training group, as well as looking at several descriptive factors, such as homework completion and client satisfaction. More specifically, this study will add to the research by looking at the effectiveness of this skills training group on a heterogeneous group of community members of different gender, age, and mental health issues, in addition to being completely voluntary. It is hypothesized that emotion regulation skills training will increase the clients’ abilities to perceive, modify, understand emotions, as well as the abilities to accept negative emotions as a part of their everyday lives.

The next chapter will summarize and evaluate additional literature on the topic of emotion regulation training. This will also include literature on DBT in general, emotion dysregulation, emotion regulation, emotion regulation training, and emotion regulation training on mental health issues. Further chapters will provide an outline of the sessions, discuss the research findings, report and discuss the results of the managing powerful emotions group on the voluntary heterogeneous group, and present further recommendations for research.
Chapter II: Literature Review

Emotion Dysregulation

According to Cole and Deater-Deckard (2009), emotion dysregulation is a mainstay in most psychopathological disorders and symptoms. However, in order to be able to treat this very common dysregulation, it is important to clearly define it. As reported by Livingstone, Harper and Gillanders (2009), emotion dysregulation is defined as the use of inflexible strategies that interfere with cognitive, social and interpersonal functioning. Although these strategies may, at one time, have served a specific function (e.g. emotional outbursts may have gotten the individual attention as a child), they are detrimental to the adult’s everyday functioning. Likewise, Gratz and Roemer (2008) define emotion dysregulation as a maladaptive response to emotions that often includes nonaccepting responses, difficulty controlling behaviours when emotionally distressed, and deficits in the functional use of emotions as information. When the strategies are ineffective, there are often fewer options available for effective emotion regulation strategies. The longer the individual uses these ineffective strategies, the less capacity for emotion regulation they will have (Cole, & Deater-Deckard, 2009). According to Livingstone et al. (2009), once emotion dysregulation has become the stable characteristic for an individual, there may be an increased risk for in developing psychopathology later in the individual’s life.

As reported by Cole and Deater-Deckard (2009), contemporary definitions of emotion dysregulation view it to be a combination of biological and behavioural processes, which include emotion, cognition, action and attention. Also, emotion dysregulation is influenced by a combination of risk factors both within the individual, as well as in the individual’s environment.

Biologically, according to research, levels of activity in certain neuronal activity in the brain are linked to emotion dysregulation in children. Also, when infants were exposed to anger, it altered their brain nerve activity, which may suggest that early stress has an impact on emotion regulation. These biological predispositions are associated with the child being more emotionally vulnerable, which is characterized by high sensitivity to emotional stimuli, emotional intensity, as well as a slow return to emotional baseline (McMain, Korman, & Dimeff, 2001).

In addition to biological factors that contribute to emotion dysregulation, it is imperative to look at environmental factors and how they affect the development of emotion dysregulation and psychopathology. Most importantly, the individual’s environment within the first few years of life is a large factor in the development of emotion dysregulation and psychopathology. According to Gratz (2003), the interaction between emotional vulnerability (i.e. biological predisposition) and the individual’s invalidating environment influence the development of emotion dysregulation and maladaptive behaviours such as self-harm. Also, as stated by McMain, Korman, and Dimeff (2001), the invalidating environment contributes to the development of emotion dysregulation because it fails to teach the child effective regulatory strategies for regulating emotions and tolerating distress. This type of environment communicates to the child that emotional experiences are wrong; therefore, they cannot freely label experiences or regulate emotional arousal. Also, because of the neglect of emotional expression, in addition to random reinforcement of emotional outburst of the parents, the child learns to fluctuate between emotional inexpression and extreme expression of emotion. Further,
according to Cole and Deater-Deckard (2009), chronic neglect and rejection from parents can influence the development of emotion dysregulation in children as it impacts both psychological and physiological regulation systems. Similarly, Gratz (2003) describes the relationship between childhood traumas in the form of physical, emotional, or sexual abuse. This type of treatment can severely increase the risk of emotion dysregulation and psychopathology in children. In addition, emotional inexpressivity, affect intensity, and reactivity in children can also increase the risk for the development of emotion dysregulation (Gratz, & Roemer, 2008).

**Emotion Regulation**

“Emotion regulation, as a field of study, examines how individuals influence, control, experience and express their emotions” (Mennin, 2004, p. 19). Emotion regulation, as described by Gratz (2007), is considered any adaptive response to one’s own emotions, despite the intensity of the emotion. The individual can be particularly reactive to emotion, or feel emotion intensely, be emotionally vulnerable, without being emotionally dysregulated. Emotion regulation includes awareness, understanding and acceptance of emotions; in addition, it involves engagement in goal-directed behaviour, flexible use of adaptive emotion regulation strategies, and the willingness to accept negative emotion as a part of everyday life. However, this is not done with the intention to be rid of the emotions. Furthermore, according to Gratz and Roemer (2008), emotion regulation should be separated from emotional control, which has its clients work to rid themselves of all emotion. However, according to emotion regulation, one can regulate their emotion while it is still present. This may involve modifying the intensity or duration of the experience by using specific techniques. Also, emotion regulation involves monitoring and evaluating the emotional experience, in addition to regulating it.

Heilman, Crisan, Houser, Miclea, and Miu (2010) found that humans often try to modify their emotional experiences. It was seen that, generally, the way the emotional experience was regulated and evaluated lead to different decisions or behaviours. Therefore, the way in which an individual appraises and regulates his or her experience may have a large effect on behaviour. More specifically, if the experience is better regulated, and appraised in a different way, the individual may engage in less maladaptive behaviours (e.g. self-harm, substance abuse, etc.).

Very similarly to emotion dysregulation, emotion regulation has biological and environmental roots. Just as neuronal function in the brain can affect emotional vulnerability within an individual, decreased neuronal function in specific areas of the brain may reduce emotional vulnerability (Cole, & Deater-Deckard, 2009). However, as discussed above, an individual may be emotionally vulnerable, while still being able to regulate their emotions (Gratz, 2007). Similarly to emotion dysregulation, Livingstone, Harper and Gillanders (2009) report that factors that affect the development of emotion regulation skills include internal characteristics such as neuroregulatory systems, behavioural traits, cognitive style, and environmental factors such as parental style. The child’s caregivers play an imperative role in the development of emotion regulation skills, as they provide regulation to the child by ways of soothing. They also teach these skills by modelling adaptive emotion regulation skills, such as distracting. The researchers also found that the type of attachment style adopted by the child to the parents or caregivers may have a huge impact on later emotion regulation strategies.
Dialectical Behaviour Therapy

One of the components of Dialectical Behaviour Therapy (DBT) is specifically targeted at the teaching of clients to understand and identify different parts of their emotional responses, determine the function of their emotions, to reduce their vulnerability to painful emotions, build more positive experiences, and change their emotional states.

Based on Cognitive Behaviour Therapy (CBT), DBT is a therapy created by Marsha Linehan for the treatment of self-harm and suicidal behaviour in women with Borderline Personality Disorder (BPD). Similarly, Wiser and Telch (1999) hold that DBT aims to reduce life-threatening and quality-of-life threatening behaviours in this population. According to Gratz (2007), research has shown DBT to be the most effective treatment for individuals with BPD as it reduces parasuicidal behaviour, substance abuse, psychiatric hospitalization, increases treatment retention, and improves overall functioning. Lynch, Chapman, Rosenthal, Kuo, and Linehan (2006) also report that DBT has earned empirical support in the treatment of BPD.

DBT approaches everyday life from an Eastern Zen philosophy that stresses acceptance and mindfulness as part of its core features (Gratz, 2007). Therefore, for example, when an individual feels anger as a result of having not been invited to a family wedding, the individual practices these concepts as opposed to engaging in substance abuse or self-harm. Also, according to McMain, Korman and Dimeff (2001), one of the major concepts in DBT includes balancing acceptance and change. These and other concepts are introduced through four specific skills training modules, including distress tolerance, interpersonal effectiveness, emotion regulation, and mindfulness skills. All of these components address emotion dysregulation in clients, focusing on all elements of the emotional experience (i.e. emotions, cognitions, expressive-motor behaviour, and action tendencies). Through these four modules, clients are provided with a multitude of emotion regulation skills options to use in moments of need (Wiser, & Telch, 1999). An individual psychotherapeutic component is also present in addition to the group based skills training modules.

According to Kirby and Baucon (2007), though DBT was originally created for the treatment of BPD, researchers and clinicians have recently been applying this therapy to psychological disorders and mental health issues beyond BPD that include emotion dysregulation as part of diagnostic etiology. Issues including emotion dysregulation as part of its diagnostic etiology include various health conditions, psychiatric diagnosis, classes of maladaptive thoughts, emotions, and behaviours, or other problems in living. DBT may also be applied to other populations, including adolescents or older adults. Furthermore, Sneed, Balestri and Belfi (2003) state that DBT has been successful in outpatient, inpatient, and residential settings.

Emotion Regulation Training

Emotion regulation training (ERT) is one of the four skills training modules in DBT. As described by Wiser and Telch (1999), clients begin this training by exploring cultural myths associated with emotions. Interpretations of these myths are discussed, and challenges to these myths are formulated (e.g. myth: “there is a right and wrong way to feel in every situation;”
The goals of ERT include assisting the client to understand and identify different parts of their emotional responses, to determine the function of their emotions, to reduce their vulnerability to painful emotions, to build more positive experiences, and to change their emotional states. Similarly, McMain, Korman and Dimeff (2001) state that one’s own vulnerability to emotions may be reduced by eating properly, sleeping the correct amount, getting a healthy amount of moderate exercise, not using substances, and increasing exposure to pleasurable activities.

Gupta, Rosenthal, Mancini, Cheavens and Lynch (2008) studied a group of 154 undergraduate women at Duke University in order to determine if emotion regulation skills mediated the effects of shame. Participants were over the age of 18 and were from a variety of fields of study. The women were given a questionnaire packet that consisted of four measures: the Eating Disorders Inventory (EDI-2), the Affect Intensity Measure (AIM), the Test of Self-Conscious Affect-3 (TOSCA-3), and the Difficulties in Emotion Regulation Scale (DERS). When given, the order of the measures in the questionnaire packet varied. Participants were debriefed after completing the measures; if necessary, participants were given resource information (i.e. mental health resources). Researchers found that levels of shame correlated with less adaptive emotion regulation skills, which lead to maladaptive behaviours in order to regulate the shame. Though findings supported the hypothesis, that ERT is effective in increasing the clients’ ability to perceive, modify, understand emotions, as well as the ability to accept negative emotions as a part of their everyday lives, there were several limitations to this study. As all participants were undergraduate students at a particular university, there is limited generalization to other populations. Future studies should incorporate clinical and community samples in order to maximize generalization and results. Also, all questionnaires used in this study were self-report measures. As these are subjective to the individual completing them, the data collected from self-report questionnaire is not as reliable as observational data. Finally, the total variance found in this study was small. This means that the effect size was smaller than expected.

Mennin (2004) found that ERT improved emotion regulation deficits, while also enhancing the overall sense of well-being and quality of life in individuals with mental health issues.

Similarly, a study by Kirby and Baucom (2007) offered group emotion regulation training in a couples context. Participants were ten married couples that ranged in age from 25 to 53. One member of each couple had graduated from the DBT skills training group. Also, in order to be part of the study, at least one member of each couple had to have experienced chronic emotion dysregulation difficulties, without current self-harm, substance dependence, domestic violence, mental retardation or antisocial personality disorder. Many participants had Axis I and II disorders, not specific to BPD. In addition, participants were currently receiving individual and couples therapy. Participants received a questionnaire packet that contained the Structured Clinical Interview for DSM-IV Axis I and Axis II Disorders (SCID), the Dyadic Adjustment Scale (DAS), the Beck Depression Inventory (BDI)-II, the Beck Anxiety Inventory (BAI), the State-Trait Anger Expression Inventory (STAXI)-2, the Difficulties in Emotion Regulation Scale (DERS), the Difficulties in Emotion Regulation Scale—Partner Version, the Positive and Negative Affect Schedule, the Efficacy Questionnaire, and the Client Satisfaction Questionnaire.
The intervention had three components, including emotion regulation, relationship skills, and the interplay of strong emotions and relationship dynamics. It consisted of 16 sessions, each lasting two hours. The sessions began with a mindfulness exercise, and then homework was discussed. The second hour consisted of the presentation of new material, and a discussion about the material to end the session. After completing all skills training sessions, those participants who had already graduated from the DBT skills training group reported significantly less depression both at post-test and follow-up. Also, interestingly, the graduates reported decreased overall emotionality at post-test, as seen through less reported positive and negative affect. However, at follow-up, graduates still reported less negative affect, while also having reported experiencing more positive affect. This suggested that graduates were more comfortable in addressing emotion. Overall, findings suggest that this skills group was effective at helping participants learn to more effectively manage their emotions (Kirby, & Baucom, 2007).

Even though there were positive findings as a result of this group, there are some limitations. This study had a small sample size, which may contribute to larger effect sizes. Also, participants were college-educated, Caucasian couples. This makes for limited generalization to other populations. Finally, the mixture of diagnoses in participants makes it difficult to decipher which psychological problems for which this treatment was more effective. It is also suggested that further studies make use of a control non-treatment or treatment as usual (TAU) group (Kirby, & Baucom, 2007).

Furthermore, in creating and validating the Difficulties in Emotion Regulation Scale (DERS), Gratz and Roemer (2004) found significant relationships between self-harm and low levels of emotional awareness, clarity and nonacceptance in both women and men.

**Mindfulness.** According to McMain, Korman, and Dimeff (2001), another very important component of ERT, as well as DBT in general, is mindfulness meditation. The mindfulness piece of DBT stems from Eastern Buddhist tradition and is practiced in Buddhism in order to end suffering and achieve spiritual enlightenment (Collard, Avny, & Boniwell, 2008). It was suggested that an increase in behavioural regulation was a major contributor to the correlation between mindfulness and well-being. Increased behavioural regulation may be seen as a decrease in negative thoughts, habits, and unhealthy behaviour (Collard, Avny, & Boniwell, 2008). As stated by McMain, Korman, and Dimeff (2001), mindfulness is often practiced at the beginning and/or end of each session. These skills teach clients to be fully aware of internal experience in the present moment in a nonjudgmental way. The therapist has clients sit with feet flat on the floor, backs slightly removed from the back of the chairs in order to be self-supporting. Clients may choose to close eyes or focus on a specific object, so as to not have eyes wandering. The therapist leads the exercise by explaining instructions to clients. Depending on the exercise, there may be complete silence, guided meditation (e.g. having clients pay attention to specific parts of the body or breath), or occasionally sound-making objects (e.g. chimes) may be used. Mindfulness exercises often range from one to five minutes. This is done as a way to informally expose clients to emotions. McMain, Korman, and Dimeff (2001) state that, with practice, mindfulness meditation allows the individual to “step back” from their emotional experience in the present moment—to observe it, be aware of it, and regulate it. Wiser and Telch
Emotion Regulation & Mental Health Issues

Though BPD is well known for its marked symptoms of emotion dysregulation, there are a plethora of other psychopathological disorders and mental health issues with which emotion dysregulation is associated. According to Gupta, Rosenthal, Mancini, Cheavens and Lynch (2008), eating disorders (ED) are highly associated with negative affectivity and chronic feelings of shame and often with the difficulty to regulate these emotions. Wiser and Telch (1999) discuss the similarity between ED and BPD behaviour. In both disorders, individuals cannot tolerate the emotion in their everyday lives and engage in maladaptive coping behaviours in order to tolerate the distress experienced from their emotions. Whereas individuals with BPD may engage in self-harm or substance abuse in order to regulate emotions, individuals with EDs engage in maladaptive eating behaviour (e.g. binging, abstaining, etc.).

Also, according to Mennin (2004), Generalized Anxiety Disorder (GAD) symptoms include emotion dysregulation. In this study, greater levels of emotion dysregulation may lead to increased vulnerability to GAD. Individuals with GAD had difficulties regulating their emotions, and may benefit from a therapeutic approach that focuses on increasing the knowledge, acceptance, and utilization of emotions. Similarly, as reported by Ehring, Tuschen, Schnulle, Fischer and Gross (2010), depression vulnerability was found to be greater in individuals with higher levels of emotion dysregulation, and lower levels of emotional acceptance.

Present in many mental health issues, self-harm is a maladaptive behaviour that is developed when the individual feeling emotional distress does not possess the skills to regulate this experience. Though, according to Gratz (2007), self-harm does not usually involve the intent to die, individuals who engage in this behaviour are at a heightened risk of suicide. According to Gratz (2003), self-harm may serve many functions for the individual engaging in the behaviour. Some of these functions include relief of unpleasant thoughts and feelings, externalization of emotional pain, distraction from emotional experience, the setting of boundaries with others, and self-punishment. The self-harming behaviour serves any or all of the above purposes at the time of emotional distress, and because of its immediate gratification, the likelihood that the individual will engage in self-harm again is increased. However, unpleasant feelings (e.g. guilt, shame) and isolation may arise as a result of this behaviour, and therefore increase the individual’s emotional crisis. Clearly, this can become a dangerous cycle. As stated by Gratz (2007), providing individuals with the skills necessary to more adaptively regulate their emotions may decrease their emotion dysregulation and, in turn, their level of self-harming behaviour. In researching the relationship between deliberate self-harm (DSH) and emotion dysregulation in a group of female undergraduate students at an urban commuter university, Gratz and Roemer...
(2008) found that DSH was more likely in women with emotion dysregulation who did not possess the adaptive skills to regulate their emotions.

This research by Gratz and Roemer (2008) suggested that, though DBT training, and more specifically emotion regulation skills training, was created for the treatment of DBT in women with parasuicidal behaviour, it may also serve other populations, psychopathological disorders, and mental health issues. As seen in the research presented above, it is evident that emotion dysregulation is a set of symptoms that is present in many individuals with these types of issues and, therefore, a therapy that targets the understanding and identification of different parts of emotional responses, determining the functions of emotions, reducing vulnerability to painful emotions, building more positive experiences, and changing current emotional states may have a large impact on symptoms, and the lives of clients.
Chapter III: Method

Participants

Inclusion criteria. Inclusion criteria for the Managing Powerful Emotions (MPE) group were minimal; individuals had to be 16 years of age or older. However, in order to participate in the research study, individuals had to be 18 years of age or older. The age range was different because the Difficulties in Emotion Regulation Scale (DERS), one of the questionnaires used in the study, was created specifically for use with adults. No diagnosis or diagnostic criteria were required for participation in this study, though the majority of participants may have qualified for a number of mental health disorders or issues (e.g. self-harm eating disorders, borderline personality disorder, post-traumatic stress disorder, anxiety disorders, depression, etc.).

Participants were selected on a “first come, first serve” basis as this group had limited room of maximum 18 participants. Though 18 participants initially signed up for the group, only nine decided to continue for the full ten weeks. In order to participate in the group, individuals had to make a ten week commitment. If a participant missed three sessions, he/she was asked to leave the group. As it was a group open to the community, there were no other exclusion criteria besides age. This meant that any community member who showed interest in the group was invited to attend.

Characteristics. Seven individuals completed both pre- and post-treatment assessments. There were five females (71.42%) and two males (28.57%) participating in the study with ages ranging from 21 to 58 years ($M = 41$, $SD = 12.38$). The marital status of each participant was recorded. Two participants reported that they were single (28.57%), while two were married (28.57%). Also, two participants were divorced (28.57%), and one was engaged (14.29%).

Ethics review. This study was approved by the St. Lawrence College Research and Ethics Board and by the Providence Care Research Review Committee.

Informed consent. Participants were given two consent forms upon arrival. One consent form was strictly for participation in the MPE community group (Appendix A), while the other was specific to participation in the research study (Appendix B). The first consent form contained information on group confidentiality, absences, ways to speak in group, socialization among group members, termination, etc. The consent form was read aloud and explained by co-facilitators. The second consent form contained information about the research study, the researcher, questionnaires being administered, confidentiality, contact information in the case of further questions, etc. Individuals were told that participation in the research study was completely optional and not contingent upon participation in the MPE group. After being signed, consent forms were collected by the co-facilitators.

Design

This study utilized a repeated measures design. Measures were administered to participants by the facilitators of the group at pre- and post- treatment. A client satisfaction survey was also administered after the final training session.
The intervention consisted of 10 weekly two-hour sessions. The content covered during the sessions included material concerning the most important themes and constructs in emotion regulation training, as well as in DBT treatment. These themes included mindfulness, emotional awareness, emotion dysregulation, function of emotions, building positive experiences, acting opposite, cognitive distortions, and empathy. The amount of homework completion was also recorded throughout the length of the 10 weeks. This was done by recording, on a session-by-session basis, whether or not each client had completed their homework.

**Hypotheses.** It was hypothesized that emotion regulation skills training, and more specifically the completion of all sessions of the Managing Powerful Emotions group would increase the clients’ abilities to perceive, modify, understand emotions, as well as gain the abilities to accept negative emotions as a part of their everyday lives. This was measured through the use of the questionnaires. Also, it was hypothesized that participants who completed more homework would yield a higher increase in overall scores from pre- to post-treatment on both the MPE Community Group Assessment and the DERS.

**Statistical Analysis.** The results were presented in tables, and these results were analyzed using the Wilcoxon nonparametric test in order to compare the mean differences within the treatment for the pre- and post- scores on the DERS assessment. Data gathered from the homework completion component were also analyzed.

**Setting/Materials**

All questionnaires were administered in the community group room within the agency. Participants were asked to complete the questionnaires in this room as they arrived for the first and final session. All participants completed these measures at the same time and in the same room. The researcher/co-facilitator was present in the room in the event that there were any questions about the measures. All group sessions were also held in this community group room. Each session participant was provided with handouts and homework sheets pertaining to that day’s group session (Appendix C). After the emotion sheet was covered in session four, a sheet was provided each session to be done for homework thereafter; it was the main tool used in the group (Appendix D).

**Measures**

**MPE Community Group Assessment.** The Managing Powerful Emotions Community Group Assessment (Personality Disorders Service, Providence Care, 2007) was used at the beginning of the ten weeks, as well as at the final meeting (Appendix E). This self-report assessment measured the client’s ability to perceive, modify, and understand emotions, as well as the ability to accept negative emotions as a part of their everyday lives. The Managing Powerful Emotions Community Group Assessment is a 9-item self-report questionnaire that is to be answered on a 7-point Likert scale ranging from 1 (very poor understanding) to 7 (extremely good understanding of the material covered in the sessions). No reliability or validity data are available for this measure.

**The Difficulties in Emotion Regulation Scale.** The Difficulties in Emotion Regulation Scale (DERS; Gratz, & Roemer, 2004) was used to measure the following six subscales of emotion regulation: nonacceptance of emotional responses, difficulties engaging in goal-directed
behaviour, impulse control difficulties, lack of emotional awareness, limited access to emotion regulation strategies, and lack of emotional clarity (Appendix F). The scale is clearly written and takes approximately eight minutes to complete. Participants require little materials in order to complete the scale; only a paper and pencil is necessary. It is aimed at a wide age range of people (18-60 years). Although this is a generally new measure, it has shown to be very promising. The scale has been tested with college students over the age of 18, as well as with a clinical sample of women with Borderline Personality Disorder (BPD). It has thus far shown to have good internal consistency (=.93). Also, each of the six subscales has shown to have a minimum Chronbach’s score of >.80 (nonacceptance=.85, goal directed behaviour=.89, impulse control=.86, emotional awareness=.80, emotion regulation strategies=.88, emotional clarity=.84) (Gratz, & Roemer, 2004).

**MPE Community Group Satisfaction Survey.** The Emotion Regulation Training Satisfaction Survey is an instrument, created by the writer, to measure the group participants’ overall satisfaction with the Managing Powerful Emotions group (Appendix G). This measure consisted of eight questions, the answers to which were to be considered when making changes for future cycles of the group.

**Procedures**

**Intervention Procedures.** The MPE community group consisted of ten-weekly sessions that ran for two hours each week on Monday afternoons. Each session began with a mindfulness exercise. The group facilitator asked participants get into position, which consisted of having participants close their eyes or focus their gaze on the floor, put their feet flat on the floor, and sit up with their backs away from the back of their chairs in order to support their own posture. This was to aid in keeping participants in the present moment while doing the exercise. The mindfulness exercise was guided meaning that the group facilitator guided the participants to focus on following their breath, noticing its temperature. The group members were also instructed to focus on the feeling in their hands, their feet in their shoes, and where they made contact to the floor. In addition, participants were asked to notice any physical pain in their bodies, to notice their emotions, and to notice any present judgements. This was done while trying to keep one’s mind in a present moment focus. When their minds wandered, participants were instructed to again focus on the present moment. This exercise took approximately five minutes to complete.

Once the exercise was completed, participants were instructed to take out the homework from the previous group. Homework was typically different for each week. However, after the fourth group, participants were asked to have a minimum of one emotion sheet completed per week. These were discussed in each following group. A portion of the group (i.e. 30-45 minutes) was dedicated to reviewing homework with the clients. If a participant’s homework was not complete, the facilitator immediately moved to the next participant.

Once homework had been reviewed, one of the facilitators presented the new material to the group. Session-by-session material included (a) goals of emotion training; (b) emotion mindfulness; (c) myths about emotion; (d) model for describing emotions; (e) functions of emotions; (f) adult pleasant events schedule; (g) reducing emotional vulnerability; (h) letting go
of emotional suffering; (i) acting opposite; (j) cognitive distortions; and (k) empathy. After this, new homework according to the session’s material was given and the session was complete.
Chapter IV: Results

As noted earlier, emotion dysregulation is an issue that is present in many areas of mental health. Previous research has shown emotion regulation training (ERT) to be helpful in improving emotion dysregulation in mental health issues such as depression, generalized anxiety disorder, alcohol abuse, substance abuse, self-injury, eating disorders, and borderline personality disorder (BPD) by increasing the clients’ ability to perceive, modify, understand emotions, as well as the ability to accept negative emotions as a part of their everyday lives.

In this study, an ERT program in the form of a Managing Powerful Emotions group was adapted from Marsha Linehan’s DBT skills training manual; this was offered to a group of seven adult community members with varying mental health issues. Two self-report questionnaires, the MPE Community Group Assessment and the DERS, were given to clients before the beginning of the first session, and after the final session. The MPE Community Group Assessment used a 7-point Likert scale scoring system, and the DERS used a 5-point Likert scale scoring system. As seen below in Table 1, the group mean response for the MPE Community Group Assessment increased by 1.64. The DERS group mean response increased by 0.62 from pre- to post-treatment. See Appendix H for raw data.

Table 1. MPE Community Group Assessment and DERS Average Pre and Post Group Responses

<table>
<thead>
<tr>
<th></th>
<th>Pre</th>
<th>Post</th>
</tr>
</thead>
<tbody>
<tr>
<td>MPE</td>
<td>3.09</td>
<td>4.73</td>
</tr>
<tr>
<td>DERS</td>
<td>2.79</td>
<td>3.41</td>
</tr>
</tbody>
</table>

Note. MPE = Managing Powerful Emotions Community Group Assessment; DERS = Difficulties in Emotion Regulation Scale

Below, Figure 1 shows a visual presentation of the average group responses for each question on the MPE Community Group Assessment.
Following, Figure 2 shows a visual presentation of the average group responses for each question on the DERS.

![Figure 2. DERS Pre and Post Average Group Response](image)

In addition to analyzing the average group responses for each questionnaire from pre- to post-group, the researcher also analyzed each participant’s average response for each questionnaire. Participant 102’s average score increased by 1.89 from pre- to post-treatment on the MPE Community Group Assessment. For the DERS, participant 102’s average response increased by 1.11, which was the highest increase on this questionnaire. Participant 105’s average response for the MPE Community Group Assessment increased by 1.45, while having reported an increased average response of 0.12 for the DERS. Participant 106 reported increased by 1.11 for the MPE Community Group Assessment. This participant’s average DERS response increased by 1.5. Participant 107’s average score on the MPE Community Group Assessment increase by 1 from pre- to post-treatment. Also, this participant reported an increased average response of 0.5 on the DERS. Participant 109 actually had a negative effect for the MPE Community Group Assessment from pre- to post-group, having had a decreased average response of 0.22. This participant also reported the lowest increase on the DERS with an increase of 0.06. Participant 110’s average response on the MPE Community Group Assessment from pre- to post-treatment increased by 1.77. This participant also increased by 0.61 on the DERS. Finally, participant 111 reported the highest increase from pre- to post-group on the MPE Community Group Assessment having had his/her average response by 3.44. The participant also reported an increase from pre- to post-group on the DERS, increase of 1.
Table 2. Managing Powerful Emotions Community Group Assessment and Difficulties in Emotion Regulation Scale Pre and Post Average Participant Responses

<table>
<thead>
<tr>
<th>Participant</th>
<th>MPE</th>
<th>DERS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pre</td>
<td>Post</td>
</tr>
<tr>
<td>102</td>
<td>2.11</td>
<td>4</td>
</tr>
<tr>
<td>105</td>
<td>3.44</td>
<td>4.89</td>
</tr>
<tr>
<td>106</td>
<td>3.11</td>
<td>4.22</td>
</tr>
<tr>
<td>107</td>
<td>4.44</td>
<td>5.44</td>
</tr>
<tr>
<td>109</td>
<td>5.11</td>
<td>4.89</td>
</tr>
<tr>
<td>110</td>
<td>1.67</td>
<td>3.44</td>
</tr>
<tr>
<td>111</td>
<td>2.78</td>
<td>6.22</td>
</tr>
</tbody>
</table>

Note: MPE = Managing Powerful Emotions Community Group Assessment; DERS = Difficulties in Emotion Regulation Scale

Below, Figure 3 shows a visual presentation of the average pre and post participant responses on the MPE Community Group Assessment.

![Figure 3. MPE Community Group Assessment Average Pre and Post Participant Responses](image)

Following, Figure 4 shows a visual presentation of the average pre and post participant responses on the DERS.

16
In addition, a Wilcoxon test was used to analyze the DERS data for the seven participants. There was a significant difference of emotion regulation skills level, Wilcoxon, \( N = 7 \), \( z = -2.366 \), two-tailed \( p = 0.018 \). The results support the hypothesis that the participants’ average responses would increase from pre- to post- treatment.

Finally, two Pearson correlations were done. The first was conducted in order to determine whether participants who completed more homework yielded better results based on the difference between their pre- and post-treatment average responses; there was no significant relationship found, \( r = .044 \), \( n = 7 \), \( p < .01 \), two tails. These results are contrary to the hypothesis that stated participants who completed more homework would yield better results. The second Pearson correlation was done in order to determine whether the two chosen questionnaires, the MPE Community Group Assessment and the DERS, were measuring a similar construct; there was no significant relationship found, \( r = .603 \), \( n = 7 \), \( p < .01 \), two tails. Table 3 below shows a visual presentation of the homework completed by participants throughout the entirety of the group.

<table>
<thead>
<tr>
<th>Participant</th>
<th>Completion</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>102</td>
<td>9/9</td>
<td>100</td>
</tr>
<tr>
<td>105</td>
<td>6/9</td>
<td>66.7</td>
</tr>
<tr>
<td>106</td>
<td>4/9</td>
<td>44.4</td>
</tr>
<tr>
<td>107</td>
<td>8/9</td>
<td>88.9</td>
</tr>
<tr>
<td>109</td>
<td>7/9</td>
<td>77.8</td>
</tr>
<tr>
<td>110</td>
<td>9/9</td>
<td>100</td>
</tr>
<tr>
<td>111</td>
<td>8/8</td>
<td>100</td>
</tr>
</tbody>
</table>

*Table 3. Participant Homework Completion*
Chapter V: Discussion

This study hypothesized that the Managing Powerful Emotions group would show increased emotion regulation skills as indication by self-report in a group of adult community members with varying mental health issues. Modest increases from pre- to post-treatment showed the skills training group to be effective in increasing participants’ emotion regulation skills, based on statistical analysis of the DERS; this confirmed the hypothesis. However, further research could look to increase these findings.

Overall, through both self-report measures, all but one participant reported that their skills improved in areas of emotion regulation assessed by the questionnaires; this is promising. However, participant 109 reported on the MPE Community Group Assessment that emotion regulation skills decreased from pre- to post-treatment. A number of factors (e.g. individual learning style, individual’s willingness to learn and participate, invalidated or unreliable questionnaire, reason for signing up for the group, etc.) could have contributed to this, as speculated by the researchers.

However, this research was consistent with current literature stating that emotion regulation training groups indicates positive effects in increasing emotion regulation skills.

The amount of homework completed by the participants was not found to be correlated with the overall change in average response on the DERS or MPE Community Group Assessment. The researchers hypothesized that this could be due to a number of factors, such as level of effort put into the homework, amount of time spent on the homework, and whether or not the participant shared his or her homework in session. These would be interesting factors to consider for future research.

Relationship to the Current Literature

A study by Kirby and Baucom (2007) also found positive results; participants showed a decrease in emotion dysregulation, while they reported an increased ability to regulate emotions. This suggested that positive emotion regulation skills contributed to better mood. More specifically, this study showed statistical significance for emotion regulation training for varying mental health disorders. This training showed effectiveness for a group of heterogeneous individuals, consisting of males and females of varying ages with varying backgrounds. This is very promising, as it shows that this type of training may be effective for a wider range of individuals than current research shows. Opposite to the hypothesis, however, the amount of homework completed by the participants was not correlated with the overall change in average response on the DERS and MPE Community Group Assessment. This could be due to a number of factors such as level of effort put into the homework, amount of time spent on the homework, and whether or not the participant shared his or her homework in the sessions. These would be interesting factors to consider for future research.

Strengths and Limitations

A major strength of this group intervention was the homework component. After skills were taught in the group session, clients were given specific tools to use at home that encouraged
the use of the skills learned. The homework given at the end of each session corresponded with that specific session’s material, and encouraged clients to record when they used the skills learned. A substantial amount of time at the beginning of the next group was then dedicated to the discussion of each client’s homework and their use of the skills over the week. This allowed clients to learn the emotion regulation skills to the best of their abilities; homework was also used to encourage participants to use the skills in their everyday lives. Also, each session was designed to build on the session before it in order to maximize learning. For example, once the emotion regulation homework sheet was introduced, participants were asked to complete a minimum of one weekly in order to assure they were using the skills learned.

Another strength of the group skills training was that it was open to anyone in the community who wanted to attend. Therefore, a heterogeneous group of individuals with different genders, age, culture, mental health issues, and intellectual functioning was formed. This allowed the researchers to assess the effectiveness of emotion regulation skills training on a wide variety of populations exemplifying emotion dysregulation. This type of study is important in order to assess emotion regulation skills training for individuals with diagnoses and issues beyond that of Borderline Personality Disorder, for which it was formed.

A limitation of the group is that the sessions are not tailored to suit each individual client as it is a group approach. Also, because it was time-limited, there often was not enough time during one session to focus on each client and assure that they were learning and practicing the skills of increasing the abilities to perceive, modify, and understand emotions, as well as increasing the abilities to accept negative emotions as a part of everyday life. In addition, this study used only self-report measures. A direct observation measure would have greatly strengthened the study. Future researchers may desire to have observation techniques in place in adjunct to the self-report measures. This is important as self-report data may not be as reliable as direct observation techniques. In addition, further researchers may include observation or questionnaires that assess emotion levels throughout treatment.

Another limitation to this study was its slight increases in average group response from pre- to post-treatment. Though there were increases in average group response on both measures, the levels of increase were not much different from the standard deviation. Therefore, increases must be regarded modest.

**Multilevel Challenges**

As with any study, there were challenges encountered at the client, program, organizational, and societal level. These are important to address as any real world factor may have an effect on the outcome of research.

**Client level.** One challenge from a client perspective is having regular attendance. As members of the community, many of these individuals have families to tend to, and jobs to be responsible for. Though the group only ran once per week, it was not tailored to suit each individual’s schedule. This can make it difficult for all participants to attend each session. This may cause individuals to miss valuable information and homework assignments.
**Program level.** Also as a result of this community group being a public service, one challenge from the program level is that any individual within the community has access to it. Though this is an advantage in many lights, because it does not cost money, many individuals who are not fully committed to attending the group will sign up for it. This means that, though the group may be full at the beginning of the ten weeks (a maximum of 18 people), many individuals do not attend any of the groups, and many will leave after a few sessions. This can often be frustrating for clinicians as many individuals on the waiting list could have benefited from the services, but did not receive the opportunity as a result of the individuals who were placed on the attendance list but did not attend or stopped attending the sessions.

**Organizational level.** From an organizational level, it can often be difficult to provide enough services to the community based on the demand. Unfortunately, as there are often budget cuts to social services, this means that there are rarely enough clinicians to handle the demand for the services offered. This can be difficult as there are so many individuals that may benefit from the service, but it is simply not an option because of limited funding.

**Societal level.** A challenge at the societal level is the label associated with attending services provided by a psychiatric hospital. Based on the negative connotation associated with these services, many individuals will not seek them out because of fear of these labels.

**Implication for the Behavioural Psychology Field**

This study is important for the Behavioural Psychology field because it shows statistical significance in the treatment of a heterogeneous group of individuals who voluntarily attended the sessions. This means that emotion regulation training may be effective in treating a wide range of individuals with varying sex, age, race, culture, and mental health issues and disorders. This is important based on the presence of emotion dysregulation in so many mental health issues and disorders. In addition, this is a cost-effective group that requires little training and could be offered to many individuals, making it readily available. This training could be offered to a wide range of individuals, in a wide range of settings, and in adjunct to other existing treatments.

**Recommendations for Future Research**

It may be beneficial to consider adding more intake criteria by asking more information of possible participants as they sign up for the group in order to decide who may best fit into the group. Although this was not an option at the time this research was conducted, it would be important to look at the effectiveness of not just the Managing Powerful Emotions treatment group, but to compare these results to a control group receiving no treatment, or treatment as usual group. This would offer more information on the group’s effectiveness.
References


Appendix A: Agency Informed Consent Sheet

INFORMED CONSENT

Community Skills-Building Groups

I, __________________________, am planning to attend and participate in the skills-building group offered by the __________________________.

Name Of Group You Are Attending:

Please check each box to confirm you have read, understand, and agree with the following:

☐ The group leaders are required to protect my confidentiality; however, group leaders are also required to report child abuse and sexually-abusive health professionals even without my consent.

☐ The group leaders may report to others if they think that I am at immediate risk of seriously harming myself or others.

☐ is a teaching hospital and students from a variety of professional disciplines are often present observing and/or helping to facilitate groups. These students are bound by the same rules of confidentiality.

☐ The group leaders will assume that they have consent to release information to other health professionals within my circle of care unless I tell them otherwise.

☐ The group is a time-limited skills development program, not long-term psychological support. I will continue to rely on my family doctor and other supports during and after participating in this group.

☐ I will not disclose any information from group to non-participants. That means not talking to my partner, family members or friends about anyone in the group in a way that may identify them.

☐ I will learn how to speak about my personal experiences in group in a way that does not burden other participants, for example, no graphic details of traumatic experiences, past or present, and no suicide threats. Instead, I will focus on my feelings and my struggles.

☐ I will show to others the same courtesy and respect I would like to be shown.

☐ I will not act out destructive and self-destructive behaviours in group, that is, no physical violence towards others, no verbal lashing out at others, no self-harm.

☐ I will not engage in physical affection or any sexual behaviour with other program participants

☐ I will not socialize with other participants outside group; this includes not socializing via electronic media such as e-mail, Facebook, Twitter, etc.

☐ I understand that I will benefit most by attending all sessions. If I miss three sessions, I understand I will be asked to leave the group.

☐ I understand that this is not a drop-in group. If I am interested in participating in a second round of the sessions, I will ask group leaders about availability, as there may be a waiting list.

☐ This group is designed to teach me new skills for dealing with emotional and interpersonal problems and I am aware this kind of program may not be helpful for everyone. If I do not believe this group is benefiting me, I may terminate my participation at any time. Similarly, if staff do not believe the group is helpful to me, I will be encouraged to find a more appropriate type of treatment.

Participant Signature: __________________________ Date: __________________________

Witness Signature: __________________________
Appendix B: Consent Form

CONSENT FORM

TITLE: Evaluating the Effectiveness of Managing Powerful Emotions Skills Training for Adults with Mental Health Issues

STUDENT: Meagan Kitts, mkitts16@student.sl.on.ca

COLLEGE SUPERVISOR: Marie-Line Jobin, (613)544-5400 ext.1112

INVITATION.

I am a student in my 4th year in the Behavioural Psychology at St. Lawrence College and I am on placement at the Providence Care Mental Health Services Personality Disorders Service. As a part of this placement, I am completing a project called an applied thesis and I am asking for your help to complete this project. The information in this form is meant to help you understand my project so that you can decide whether or not you want to participate. Please read the information below carefully and ask all the questions you might have before deciding whether or not to participate.

WHAT IS THE PURPOSE OF THE STUDY?

The purpose of the research is to look at whether or not the “Managing Powerful Emotions” community skills training group offered by Providence Care Mental Health Services is helpful. If you choose to participate, I will look at how effective the group is in helping all its participants learn the material covered in the sessions about emotion regulation. This information is important so that the group may be evaluated to see if it is effective or if any changes are needed.

WHAT WILL YOU NEED TO DO IF YOU TAKE PART?

Firstly, in order to take part in the research, you will need to participate in the Managing Powerful Emotions group. This group will run for ten weeks, each session lasting for approximately two hours. The group will run from October 18 to December 20.

Secondly, you will need to agree to let me review information on your amount of emotion dysregulation, using two questionnaires. You will need to complete the Managing Powerful
Emotions Community Group Assessment, and the Difficulties in Emotion Regulation Scale both at the beginning and end of the group.

The Managing Powerful Emotions Community Group Assessment is a nine-item questionnaire. It contains questions that will look at how well the material covered in the Managing Powerful Emotions group helped all the members of the group with emotion regulation.

The Difficulties in Emotion Regulation Scale is a 36-item questionnaire. It measures six areas of emotion regulation.

Also, you will be asked to complete a survey following the final group session that will include questions about whether or not you think the group was helpful to you.

It should take approximately 15 minutes to complete all questionnaires. There will be a staff member present in case you need more instructions.

WHAT ARE THE POTENTIAL BENEFITS TO ME OF TAKING PART?

The potential benefits to you if you agree to participate in the research study are that you would be adding to research about the effectiveness of the group, which may help individuals who have difficulty with emotion regulation.

WHAT ARE THE POSSIBLE DISADVANTAGES AND RISKS OF TAKING PART?

A risk of participating in this research is learning that the information collected from your questionnaires show that the material you have learned did not help the group as a whole. This may be disappointing.

WILL MY TAKING PART IN THIS PROJECT BE KEPT PRIVATE?

All information you provide through the questionnaires will be kept confidential. All information that is recorded will be stored in a locked filing cabinet at the Personality Disorders Service at Providence Care Mental Health Services for seven years. Any information stored on computer will be password protected. This password will only be available to staff and student. If any information conveys that you are endangering yourself or others, this privacy will have to be broken. Otherwise, your scores will only be used in order to add to the overall group scores to see if the training is helpful.

DO YOU HAVE TO TAKE PART?
It is up to you to decide whether or not to take part. Firstly, you will be asked to participate in the ten week Managing Powerful Emotions group for approximately two hours weekly beginning October 18, and ending December 20. If you do decide to take part, you will be asked to sign this consent form. Secondly, you will be asked to complete two questionnaires about emotion management at the first and final session. Finally, you will be asked to complete a satisfaction survey at the final session. It should take approximately 15 minutes to complete all the questionnaires and a staff member will be present in case you need additional instructions. If you do decide to take part, you are still free to withdraw at any time, without giving any reason, and be able to continue the group without any penalty. However, there is no guarantee that your data up to the date you withdraw will not be used because it will be coded and anonymous, consequently it will be confidential. Though the research is meant to identify the group’s effectiveness as a whole, you may also discuss your individual results with the main group facilitator. Please note that you may also participate in the Managing Powerful Emotions community group without participating in the research project.

CONTACT FOR FURTHER INFORMATION.

This project has been approved by the Research Ethics Board at St. Lawrence College and the Research Ethics Board at Providence Care. The project will be developed under the supervision of Marie-Line Jobin, my supervisor from St. Lawrence College, Dr. Margo Rivera, my supervisor at Providence Care and Karen Gagnon of Providence Care. I really appreciate your cooperation. If you have any additional questions or concerns, feel free to ask me, Meagan Kitts at mkits16@student.sl.on.ca, or you can contact my College Supervisor, Marie-Line Jobin (613)544-5400 ext.1112. You may also contact the SLC Research Ethics Board at appliedresearch@sl.on.ca or Dr. John Puxty, Chair, Providence Care Research Review Committee 613-548-5567 ext. 5645.

CONSENT

If you agree to participate in the project, please complete the following form and return it to me as soon as possible. A copy of this signed document will be given to you for your own records. An additional copy of your consent will be retained at the agency and in a secure location with the Research Ethics Board at St. Lawrence College.

CONSENT

By signing this form, I agree that:

- The study has been explained to me.
- All my questions were answered.
• Possible harm and discomforts and possible benefits (if any) of this study have been explained to me.
• I understand that I have the right not to participate and the right to stop at any time.
• I am free now, and in the future, to ask any questions about the study.
• I have been told that my personal information will be kept confidential.
• I understand that no information that would identify me will be released or printed without asking me first.
• I understand that I will receive a signed copy of this consent form.

I hereby consent to participate.

Participant/Parent/Guardian Printed Name: ____________________________

Age of Participant (If Under 18):______________

Signature: _______________________________ Date: _______

SLC Student Signature: __________________ Date: _______

Printed Name: ____________________________
### MANAGING POWERFUL EMOTIONS GROUP

**Course Outline**

<table>
<thead>
<tr>
<th>Group 1:</th>
<th>Group 6:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Goals of Emotion Regulation Training</td>
<td>- Adult Pleasant Events Schedule</td>
</tr>
<tr>
<td>- Two Kinds of Emotional Experiences</td>
<td>- Building Positive Experiences</td>
</tr>
<tr>
<td>- Homework Sheet – Emotion Mindfulness</td>
<td>- Reducing Vulnerability</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Group 2:</th>
<th>Group 7:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Mindfulness Handout 1 – Introduction to Mindfulness</td>
<td>- Dandelion Story</td>
</tr>
<tr>
<td>- Mindfulness Handout 2 – Being Non-Judgemental</td>
<td>- Letting Go of Emotional Suffering</td>
</tr>
<tr>
<td>- Mindfulness Handout 3 – Getting Ready to Practice Mindfulness</td>
<td></td>
</tr>
<tr>
<td>- Mindfulness Handout 4 – Elements of Mindfulness</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Group 3:</th>
<th>Group 8:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Emotion Regulation Assumptions</td>
<td>- Acting Opposite</td>
</tr>
<tr>
<td>- Myths About Emotions</td>
<td></td>
</tr>
<tr>
<td>- Theory of Emotions</td>
<td></td>
</tr>
<tr>
<td>- Homework Sheet – Emotional Awareness Sentence Completion</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Group 4:</th>
<th>Group 9:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Emotion Dysregulation</td>
<td>- Cognitive Distortions</td>
</tr>
<tr>
<td>- How are you Feeling Today?</td>
<td>- Empathy Definition</td>
</tr>
<tr>
<td>- Model for Describing Emotions</td>
<td>- Empathy Mindfulness</td>
</tr>
<tr>
<td>- Guide for Emotion Sheet</td>
<td>- Lesson Empathy</td>
</tr>
<tr>
<td>- Sample Emotion Sheet</td>
<td>- Reversible Figure</td>
</tr>
<tr>
<td>- Blank Emotion Sheet</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Group 5:</th>
<th>Group 10:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Functions of Emotions</td>
<td>- Emotion Regulation Review</td>
</tr>
<tr>
<td>- Ways to Describe Emotions</td>
<td>- Putting Empathy Into Practice</td>
</tr>
<tr>
<td>- Homework Sheet – Emotion Diary</td>
<td>- Random Acts of Kindness</td>
</tr>
</tbody>
</table>

Adapted From Skills Training Manual for Treating Borderline Personality Disorder by Marsha Linehan © 1993
By The Personality Disorders Service at Providence Care Manual & Health Services (Aug. 2010)
Appendix D: Emotion Regulation Homework Sheet

EMOTION REGULATION HOMEWORK SHEET 1
Observing and Describing Emotions

NAME: ___________________________ DATE: ___________________________

Select a current or recent emotional reaction and fill out as much of this sheet as you can. If the prompting event for the emotion you are working on is another emotion that occurred first (for example, feeling afraid prompted getting angry at yourself), then fill out a second homework sheet for that first emotion. Write on a separate page if you need more room.

EMOTION NAMES: ___________________________ INTENSITY (0-100): ______________

PROMPTING EVENT for my emotion: (who, what, when, where) What started the emotion?

INTERPRETATIONS (beliefs, assumptions, appraisals) of the situation?

BODY CHANGES and SENSING: What am I feeling in my body?

BODY LANGUAGE: What is my facial expression? posture? gestures?
ACTION URGES: What do I feel like doing? What do I really want to say?

What I SAID OR DID in the situation: (Be specific).

What AFTER EFFECT does the emotion have on me (my state of mind, other emotions, behaviour, thoughts, memory, body, etc.)?

FUNCTION OF EMOTION What purpose did the emotion serve (communicate, force me to pay attention, motivate me, cover another emotion)?

TAKING A SECOND LOOK Is there another way to interpret this situation? If so, how would it affect me?

SUMMARY What did I learn about myself from doing this Emotion Sheet?

Adapted from Linehan (1993) by the Personality Disorders Service
Appendix E: MPE Community Group Assessment

We would like to know how well you think you deal with your emotions. Please circle the number that best reflects your current ability, that is, within the past month.

1. How well do you think you understand your emotions?
   
   Very Poorly 1 2 3 4 5 6 7 Extremely Well

2. How well are you able describe your emotions?
   
   Very Poorly 1 2 3 4 5 6 7 Extremely Well

3. How well do you think you manage your strong emotions?
   
   Very Poorly 1 2 3 4 5 6 7 Extremely Well

4. How well do you manage the things that reduce your vulnerability to painful emotions, like eating, sleeping, exercise, and physical illnesses?
   
   Very Poorly 1 2 3 4 5 6 7 Extremely Well

5. How well are you able to experience and prolong positive emotions?
   
   Very Poorly 1 2 3 4 5 6 7 Extremely Well

6. How well are you able to show others that you understand their emotions?
   
   Very Poorly 1 2 3 4 5 6 7 Extremely Well

7. How well are you able to identify (name) the emotions you feel?
   
   Very Poorly 1 2 3 4 5 6 7 Extremely Well

8. How well are you able to identify the event that ‘causes’ you to have an emotion?
   
   Very Poorly 1 2 3 4 5 6 7 Extremely Well

9. How well do you think you accept your emotions, even when they are painful?
   
   Very Poorly 1 2 3 4 5 6 7 Extremely Well
Appendix F: Difficulties in Emotion Regulation Scale (DERS)

DERS
Please indicate how often the following statements apply to you by writing the appropriate number from the scale below on the line beside each item:

<table>
<thead>
<tr>
<th></th>
<th>almost never (0-10%)</th>
<th>sometimes (11-35%)</th>
<th>about half the time (36-65%)</th>
<th>most of the time (66-90%)</th>
<th>almost always (91-100%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>I am clear about my feelings.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>I pay attention to how I feel.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>I experience my emotions as overwhelming and out of control.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>I have no idea how I am feeling.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>I have difficulty making sense out of my feelings.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>I am attentive to my feelings.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>I know exactly how I am feeling.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>I care about what I am feeling.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>I am confused about how I feel.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>When I’m upset, I acknowledge my emotions.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>When I’m upset, I become angry with myself for feeling that way.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>When I’m upset, I become embarrassed for feeling that way.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>When I’m upset, I have difficulty getting work done.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>When I’m upset, I become out of control.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>When I’m upset, I believe that I will remain that way for a long time.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>When I’m upset, I believe that I’ll end up feeling very depressed.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>When I’m upset, I believe that my feelings are valid and important.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>When I’m upset, I have difficulty focusing on other things.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>19</td>
<td>When I’m upset, I feel out of control.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20</td>
<td>When I’m upset, I can still get things done.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>21</td>
<td>When I’m upset, I feel ashamed with myself for feeling that way.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>almost never</td>
<td>sometimes</td>
<td>about half the time</td>
<td>most of the time</td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>--------------</td>
<td>-----------</td>
<td>---------------------</td>
<td>-----------------</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(0-10%)</td>
<td>(11-35%)</td>
<td>(36-65%)</td>
<td>(66-90%)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(91-100%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

22) When I’m upset, I know that I can find a way to eventually feel better.
23) When I’m upset, I feel like I am weak.
24) When I’m upset, I feel like I can remain in control of my behaviors.
25) When I’m upset, I feel guilty for feeling that way.
26) When I’m upset, I have difficulty concentrating.
27) When I’m upset, I have difficulty controlling my behaviors.
28) When I’m upset, I believe that there is nothing I can do to make myself feel better.
29) When I’m upset, I become irritated with myself for feeling that way.
30) When I’m upset, I start to feel very bad about myself.
31) When I’m upset, I believe that wallowing in it is all I can do.
32) When I’m upset, I lose control over my behaviors.
33) When I’m upset, I have difficulty thinking about anything else.
34) When I’m upset, I take time to figure out what I’m really feeling.
35) When I’m upset, it takes me a long time to feel better.
36) When I’m upset, my emotions feel overwhelming.
Appendix G: Emotion Regulation Training Satisfaction Survey

Please fill out this survey by circling the number coinciding with the answer you choose. This survey will take approximately four minutes to complete. Please complete in blue or black ink.

1= completely dissatisfied  2= dissatisfied  3= neutral  4= satisfied  5=completely satisfied

1. ERT helped me to accept emotions that I cannot change.  
   1  2  3  4  5

2. ERT helped me to create and stick to goals.  
   1  2  3  4  5

3. ERT helped me to control myself when I am feeling emotional.  
   1  2  3  4  5

4. ERT helped me to learn about my emotions.  
   1  2  3  4  5

5. ERT taught me strategies to help regulate my emotions.  
   1  2  3  4  5

6. ERT taught me about my emotions, the emotions of others, and when to expect these emotions.  
   1  2  3  4  5

7. Overall, I am happy with the services that I have received.  
   1  2  3  4  5

8. I would recommend this service to anyone in the community who was looking for such a service.  
   1  2  3  4  5
## Appendix H: Raw Data

<table>
<thead>
<tr>
<th>Participant</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
<th>Q5</th>
<th>Q6</th>
<th>Q7</th>
<th>Q8</th>
<th>Q9</th>
<th>Post</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
<th>Q5</th>
<th>Q6</th>
<th>Q7</th>
<th>Q8</th>
<th>Q9</th>
</tr>
</thead>
<tbody>
<tr>
<td>102</td>
<td>3</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>105</td>
<td>4</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>4</td>
<td>4</td>
<td>1</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>1</td>
<td>3</td>
<td>5</td>
<td>5</td>
<td>3</td>
<td>5</td>
<td>4</td>
<td>4</td>
<td>7</td>
</tr>
<tr>
<td>106</td>
<td>5</td>
<td>3</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>5</td>
<td>5</td>
<td>1</td>
<td>3</td>
<td>5</td>
<td>3</td>
<td>5</td>
<td>4</td>
<td>4</td>
<td>7</td>
<td>3</td>
<td>4</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>107</td>
<td>3</td>
<td>6</td>
<td>2</td>
<td>6</td>
<td>5</td>
<td>7</td>
<td>5</td>
<td>4</td>
<td>2</td>
<td>6</td>
<td>5</td>
<td>4</td>
<td>7</td>
<td>4</td>
<td>9</td>
<td>5</td>
<td>7</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>109</td>
<td>5</td>
<td>6</td>
<td>4</td>
<td>5</td>
<td>5</td>
<td>6</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>6</td>
<td>4</td>
<td>4</td>
<td>5</td>
<td>5</td>
<td>6</td>
<td>4</td>
<td>5</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>110</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>4</td>
<td>3</td>
<td>3</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>5</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>111</td>
<td>3</td>
<td>3</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>6</td>
<td>7</td>
<td>6</td>
<td>4</td>
<td>6</td>
<td>6</td>
<td>7</td>
<td>7</td>
<td>7</td>
<td></td>
</tr>
</tbody>
</table>