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The Addition of a Dissociation Module to Dialectical Behavior Therapy

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The Addition of a Dissociation Module to Dialectical Behavior Therapy

by

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of the requirements for the degree of Doctor of Psychology

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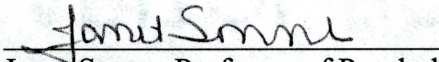
Each person whose signature appears below certifies that this project in his/her opinion is adequate, in scope and quality, as a doctoral project for the degree of Doctor of Psychology.



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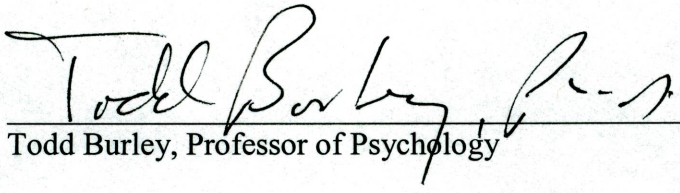

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Dedication

I dedicate this project to my loving family Holly, Raymond Samuel, Ray, Shelly, Stacy, Scooby, Apollo, Fraidy, and Mouse, whose great love provided me with the strength needed to achieve my personal and professional goals. I also send a big thank you to my friends Karen, Lisa, Tanya, and Noel; the entire third year class; Todd, my lab mate, and the folks at work that helped pick up the slack when I was in the final crunch.

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Abstract

The Addition of a Dissociation Module to Dialectical Behavior Therapy

by

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Loma Linda University, September 2004
Dr. Janet Sonne, Chairperson

Dialectical Behavior Therapy (DBT; Linehan, 1993a), a manualized treatment for Borderline Personality Disorder (BPD) was developed before the Diagnostic and Statistical Manual – 4th Ed. (DSM-IV, APA, 1994) added dissociative symptoms to the diagnostic criterion for BPD. Hence, the manual (1993b) did not properly address the assessment and treatment of dissociation, a necessity being mandated by the American Psychiatric Association (Oldham et al., 2001) in their treatment guidelines for BPD. Recent studies (Bohus, et al. 2000; Koons et al. 2001) confirm this hypothesis and have shown that DBT is effective with lower levels of dissociation but does not address more pathological levels of dissociation. Suggestions will be made in this project that would augment the DBT treatment model for BPD to include assessment, interventions, and supplemental considerations in targeting dissociation at all levels experienced by those diagnosed with BPD.

Introduction

Borderline Personality Disorder (BPD) is one of the most controversial and the most researched personality disorders (Hoffman, Buteau, Hooley, Fruzzetti, & Bruce 2003). The 4th Edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV; American Psychological Association, 1994) recognized that many people diagnosed with BPD also experience episodes of transient paranoid ideation or dissociative symptoms. Many of these same individuals have a comorbid diagnosis that includes dissociation (Boon & Draijer, 1993; Dell, 1998; Ellason, Ross, & Fuchs 1996; Gershuny & Thayer, 1999; Horevitz & Braun, 1984; Lauer, Black, & Keen 1993; Lipsanen, Korkeila, & Peltola, 2004; Ross, Miller, Reagor, Bjomson, Fraser, & Anderson, 1990; Sar, Kundakci, & Kiziltan, 2003; Scroppo, Drob, Weinberger, & Eagle, 1998; Stone, 2000; Tezcan, Atmaca, & Kuloglu, 2003; Tutkun, Sar, Yargic, Ozpulat, Yanik, & Kiziltan, 1998; Wildgoose, Waller, & Clarke, 2000; Yargic, Sar, Tutkun, & Alyanak, 1998; Zanarini, Ruser, & Frankenburg, 2000a; 2000b). Hence, it is important to include an assessment and specific guidelines for the treatment of dissociation when treating those diagnosed with BPD.

The current most popular manualized treatment for BPD, namely, Dialectical Behavior Therapy (DBT; Linehan, 1993a) was developed before the addition of the diagnostic criterion addressing dissociation. Therefore, the manual did not directly nor adequately address the assessment and treatment of dissociation. Suggestions will be made in this project that would augment the DBT treatment model for BPD to include interventions targeting dissociation.

Note: Linehan (1993a) states that the empirical findings of her treatment are limited to women diagnosed with BPD. Hence, in keeping with this fact, and Linehan's precedent, the pronouns of *she* and *her* will be used throughout this paper.

History of Borderline Personality Disorder

While the validity of Borderline Personality Disorder is now generally accepted, a review of the literature suggests that there have been many formulations of this disorder. The following section presents an overview of the history of efforts to conceptualize BPD.

Otto Kernberg, a renowned psychoanalyst and forefather in research and treatment of BPD, examined the etiology of what he termed *borderline personality organization*. He identified a variety of symptoms in these clients, including free-floating anxiety, obsessive-compulsive symptoms, multiple phobias, dissociative reactions, hypochondriacal preoccupations, conversion symptoms, paranoid trends, and substance abuse. He warned though that descriptive symptoms were not sufficient for a definitive diagnosis (Kernberg, 1975). Instead, Kernberg theorized that the diagnosis rested on structural criteria, which incorporated Hartmann's ego psychology and Mahler's object relations theory (Kernberg, 1977).

Drawing from ego psychology and object relations, Kernberg proposed four key features common to BPD: (1) nonspecific manifestations of ego weakness, (2) a shift toward primary-process thinking, (3) defensive operations that include splitting, primitive idealization, projection, denial and omnipotence and devaluation; and (4) pathological internalized object relations. Kernberg also theorized that clients with narcissistic, antisocial, schizoid, paranoid, infantile, and cyclothymic personality disorders were all characterized by an underlying borderline personality organization. While Kernberg considered a structural understanding of clients diagnosed with BPD, others aimed at descriptive diagnostic criteria.

Grinker, Werble, and Drye (1989) described the following four features as central in the borderline syndrome: (1) anger as the main or only affect, (2) defects in interpersonal relationships, (3) absence of consistent self-identity, and (4) pervasive depression. More importantly, they found that those diagnosed with borderline syndrome were not suffering from schizophrenia (Gabbard, 1994). Grinker found that the clients did not deteriorate into schizophrenia but they remained, as Schmideberg (1956) put it, *stably unstable.*

Grinker et al. (1989) suggested that the best way to describe the diagnosis of borderline personality organization was through empirical means. They performed a cluster analysis of 60 clients diagnosed with borderline syndrome in a hospital in Chicago. These clients were found to have many similarities that could be placed along a continuum. One extreme of the continuum was called the *psychotic border* (Type l) and the opposite end was named the *neurotic border* (Type IV). In between the two extremes were two additional groups. The *core borderline syndrome* group (Type II) had a predominantly negative affect and difficulty maintaining stable interpersonal relationships and the *as-if* group (Type III) was characterized by the need to *borrow their identity* from others.

Gunderson and Singer (1975) systematically reviewed the literature available at that time and identified key clinical descriptive characteristics of BPD. They concluded that those diagnosed with BPD could be described based on five areas of functioning: social adaptation, impulse-action patterns, affects, psychotic symptoms, and interpersonal relations. These areas were selected from a systematic review of the literature regarding clinical descriptive characteristics. Following this, Gunderson and Singer delineated six

descriptive features as the basis for the diagnosis of BPD: (1) an intense affect of a predominantly depressed or angry nature, (2) impulsivity, (3) a superficial adaptation to social situations, (4) transient psychotic episodes, (5) a proneness to loose thinking in projective testing or other unstructured situations, and (6) a vacillating pattern of relationships that shifts from extreme dependency to transient superficiality.

Another major contribution to conceptualizing BPD came from Masterson (1972), who also relied heavily on Mahler's (1971) object relations theory. Instead of focusing on the behavior of the pre-borderline child, as Kernberg did, Masterson examined the mother's role in the child's development. Masterson suggested that fear of abandonment was the central factor. He believed that the mother of the pre-borderline child withdrew emotionally when her child acted in an independent manner. This process appeared to be especially critical between the ages of 18 and 36 months, the phase Mahler termed *separation-individuation*. This created specific developmental challenges whenever the child encountered opportunities to become independent. The child faced a seemingly insoluble dilemma, behave independently and lose emotional support, or accept dependence and garner the affections of her mother (Zanarini & Frankenburg, 1997; Gabbard, 1994).

Adler and Buie (1979) offered another perspective of BPD based on a deficit or *insufficiency* model. They suggested that failures in early mothering resulted in a failure to develop object constancy. Because the pre-borderline child's mother was inconsistent or unreliable and often insensitive or non-empathic, the child failed to develop a consistent view of him or herself, or others. Therefore, the child was unable to self-soothe and find comfort in times of distress (Zanarini & Frankenburg, 1997).

Kohut (1971) and others (Chessick, 1979; Feldman, Zelkowitz, & Weiss, 1995) suggested that the child learned maladaptive behavior and cognitions from the inconsistent caretaker. Beck, Rush, Shaw, and Emery (1979) described the developing child as building up models of the self and other, based on repeated patterns of interactive experience. These models are the basic representations and assumptions that the child uses to predict and relate to the world. They become relatively stable and persistent and are unlikely to be modified by subsequent experience.

Theodore Millon (1981) stated that the borderline individual's lack of a clear and coherent sense of identity is central to the pathogenesis of the disorder. He proposed that identity confusion/diffusion is the result of biopsychosocial factors. Millon also contended that borderline individuals more often have a family history characterized by high autonomic reactivity and hyper-responsiveness. This family history combined with a poor *goodness of fit* between the temperament of the child and the caregiver (Thomas & Chess, 1977), predisposed the individual to inconsistent responses from their caregivers. The inconsistency then led to a hypersensitivity to loss or separation and poorly controlled impulses (Millon, 1981).

Marsha Linehan developed her Dialectical Behavior Therapy for the treatment of borderline personality disorder based on the biosocial theory that Millon proposed. Linehan (1987) described the behavior formulation of borderline pathology as a dysfunction of emotional regulation. This dysfunction is the result of high autonomic reactivity and an invalidating environment. Hence, the child within this dynamic is unable to learn how to regulate her emotions and impulses. This perspective and

dialectical behavior therapy will be discussed in greater detail at a later point in this paper.

Definition of Borderline Personality Disorder, Factors and Prevalence

The DSM-IV (APA, 1994) states that "the essential feature of BPD is a pervasive pattern of instability of interpersonal relationships, self-image, and affects and marked impulsivity that begins by early adulthood and is present in a variety of contexts" (p. 650). To be diagnosed with BPD, one must meet at least five of the following criteria:

1. Frantic efforts to avoid real or imagined abandonment. Note: Do not include suicidal or self-mutilating behavior covered in Criterion 5.
2. Patterns of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation.
3. Identity disturbance: markedly and persistently unstable self-image or sense of self.
4. Impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating). Note: Do not include suicidal or self-mutilating behavior covered in Criterion 5.
5. Recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior.
6. Affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days).
7. Chronic feelings of emptiness.
8. Inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights).
9. Transient, stress-related paranoid ideation or severe dissociative symptoms. (p. 654)

These criteria can be divided into three factors: disturbed relatedness (i.e., unstable relationships, identity disturbance, chronic feelings of emptiness and stress-

related paranoid ideation or dissociation), behavioral dysregulation (i.e., impulsivity in two areas and suicidal or self-mutilative behavior), and affective dysregulation (i.e., affective instability, inappropriate anger and avoidance of abandonment) (Sanislow et al., 2002).

The prevalence of BPD is estimated to be 2% of the general population and 10% of those seen in outpatient mental health clinics. In addition, 20% of all psychiatric inpatients meet the criteria for BPD. Of all patients diagnosed with BPD, 75% of them are women. (DSM-IV, 1994).

In 1994, the DSM-IV criteria for Borderline Personality Disorder (BPD) were amended and an additional criterion, "transient, stress-related paranoid ideation or severe dissociative symptoms" was added. The new criterion tapped cognitive-perceptual dysfunction and was originally advocated for in the Diagnostic and Statistical Manual of Mental Disorders, Third Edition (APA, 1987) because of its centrality in descriptions of those diagnosed with BPD (Friedman, 1975; Kernberg, 1967; Knight, 1953; Masterson, 1972; Zetzel, 1971). Since then, nine studies (see Table 1) demonstrated that such cognitive-perceptual disturbances are present in a significant percentage of those diagnosed with borderline personality disorder. Table 1 shows the prevalence of the different disturbances in those diagnosed with BPD. In addition, these cognitive-perceptual symptoms discriminated those diagnosed with BPD from patients diagnosed with other personality disorders in a majority of the studies (Widiger, Frances, Pincus, Ross, First, & Wakefield 1996).

Table 1

Prevalence of cognitive-perceptual symptoms in borderline personality disorder samples

Cognitive/perceptual problem	Study[a]	Range (%)
Depersonalization	1, 3, 5, 7, 8, 9	30-85
Derealization	1, 3, 4, 7, 8, 9	30-92
Paranoid experiences	3, 5, 6, 7, 8, 9	32-100
Hope/worthlessness	3, 7, 8	77-88
Visual illusions	4, 5, 6, 7, 9	24-42
Muddled thinking	4	52
Magical thinking	5, 6, 9	34-68
Ideas of reference	5, 6, 9	49-74
Odd speech	5, 6	30-59
Disturbed thoughts	2, 9	39-68

[a] 1 = Frances, et al. 1984; 2 = Pope, et al. 1985; 3 = Chopra and Beatson 1986; 4 = George and Soloff 1986; 5 = Jacobsberg et al. 1986; 6 = Widiger et al. 1987; 7 = Links et al. 1988; 8 = Silk et al. 1989; 9 = Zanarini et al. 1990.

When asked about the addition of this ninth criterion, 15 of the 21 advisors involved in the DSM-IV task force endorsed the inclusion. These advisors, backed by the arguments by Gunderson (1979; 1984) and Frosch (1988), "felt strongly that this feature is central to the borderline construct and that its addition would likely capture one of the most discriminating features of the disorder" (Widiger et al., 1996, p. 724).

Additional studies have since shown that clients with BPD experience moderate to severe dissociative symptoms and a wide variety of dissociative experiences (Zanarini et al., 2000a). Further, dissociation contributed to an aggravation of dysfunctional behaviors (Bohus, Haaf, & Stiglmayr, 2000), and elevated levels of dissociation were indicative of higher levels of overall dysfunction (Wildgoose et al., 2000). It would follow that a treatment emphasis on dissociation would improve the client's level of functioning and decrease remaining borderline symptoms (Ellason & Ross, 1996). The American Psychiatric Association (Oldham, et al. 2001) claimed that the management and identification of comorbid DID or prominent dissociative symptoms in those with BPD are mandated. Furthermore, reducing dissociative symptoms would allow clients to more fully integrate valuable therapeutic experiences and critical information.

History of Dissociation

The clinical roots of dissociation are embedded in the history of hypnosis. Mesmer, one of the first to study hypnosis, focused on sensory, motor and convulsive events. However, Mesmer's contemporary, de Puységur, thought that there was much more to the events that Mesmer described and began to study what he called *lucid sleep* (Kravis, 1988). Lucid sleep began after a subject of de Puysegur was unable to recall events that had happened in the hypnotic state (Ellenberger, 1974). He took this as

evidence that the conscious mind could be divided or disconnected from other parts of itself. He argued that this process was different from the process of forgetting. The process that he described is what we now call dissociation.

It was not until a century later, though, that dissociation was again the focus of study (Azam, 1892; Janet, 1925/1976; James, 1890; Prince, 1921; Sidis & Goodhart, 1905). Janet posited that under ordinary circumstances, people automatically integrated new information into their cognitive schemas without conscious attending. Therefore, when an individual experienced a discontinuity in their conscious awareness, they found that they were unable to assimilate or integrate the new information into their memory or identity. He described this occurrence as *désagrégation*, which is the splitting off of mental processes from consciousness. He found that in these circumstances, the information was no longer accessible to the dissociating person as it would be under ordinary conditions, a finding supported by more contemporary research (Cardeña, 1994, van der Kolk & van der Hart, 1989; Woody & Bowers, 1994).

Much of what we experience during the day is not in our conscious awareness. Under normal circumstances, people automatically integrate new information by doing things without needing to pay attention. Most of our experiences, values, habits, and innate or acquired skills are automatically integrated into our existing cognitive schemas. These automatic adaptations, or what Janet called *automatisms*, are actions that are triggered by ideas and accompanied by emotions. They may range from a grasping reflex to a much more complex execution of a particular skill (Janet, 1925). Janet hypothesized that these automatisms were biologically and psychologically encoded (Janet, 1925;

Kihlstrom, 1984). He coined the term *subconscious* to describe the memories that are automatically stored.

Janet claimed that our emotions, thoughts and sensations are unified into a single consciousness and are under voluntary control. Successful integration into the memory system depends on the cognitive assessment of new experiences. If an experience is new or frightening, our cognitive schemas may not be able to incorporate it, possibly causing a split from voluntary control and conscious awareness. These unintegrated fragments, or newly formed pathological automatisms might later surface and influence an individual's perceptions, affects, and behavior (Janet, 1889, 1893, 1898, 1965; Marmer, 1996; van der Hart & Friedman, 1989; van der Hart & Horst, 1989).

Current Views of Dissociation

Etzel Cardeña (1994) recognized the semantic confusion surrounding the term dissociation. It has been used as "a descriptive or explanatory concept for such disparate phenomena as hypnosis, and automatic behaviors (e.g. Hilgard, 1986); to distinguish between various types of memory (e.g. Kihlstrom, 1982); in relation to some forms of psychopathology (e.g., American Psychiatric Association, 1987; Spiegel & Cardeña, 1991) and some cognitive responses to trauma (e.g., Cardeña & Spiegel, 1993)" (p. 15). From this, Cardeña offered three different views of dissociation, (1) dissociation as nonconscious or nonintegrated mental modules or systems; (2) dissociation as an alteration in consciousness wherein disconnection/disengagement from the self or the environment is experienced; and (3) dissociation as a defense mechanism.

Dissociation as nonintegrated mental systems. The concept that humans have limited access to all mental processes pervades all of psychology including

psychodynamic theory, cognition and artificial intelligence (Baars, 1988; Minsky, 1985). In the broadest sense, dissociation describes perceptions and behaviors that happen outside of conscious awareness. These range from behaviors in one's periphery (e.g., driving and talking to someone simultaneously) to complete unawareness of the activity (e.g., sleepwalking). Nemiah (1991) proposed that dissociation is limited to that which is inaccessible to voluntary recall.

Dissociation as an alteration in consciousness. Dissociation has been conceptualized along a continuum from more *normal* dissociative states such as daydreaming (Singer, 1966) to more pathological forms of dissociation as found in the DSM-IV (1994). However, Cardeña asserted that dissociation should not be applied to ordinary experiences (i.e., highway hypnosis) if it is to be useful to clinical psychology. Instead, it should pertain to qualitative departures from one's ordinary way of experiencing consciousness. This departure includes the disengagement of the self and/or their surroundings, thus altering the experience of the individual (Noyes & Kletti, 1977; Steinberg, 1991; Cardeña, 1994; Frankel, 1990).

The clinical syndromes of depersonalization and derealization illustrate a dissociative way of experiencing one's surroundings. The DSM-IV (1994) described depersonalization as a feeling of detachment or estrangement from one's self while maintaining intact reality testing. With derealization, the person may not doubt the reality of self, but instead, experience surroundings and others as not quite real, or as if she is in a dream-like world devoid of substance (Cardeña, 1994; Reed, 1988; Steinberg, 1991).

Dissociation as a defense mechanism. According to Freud, a defense mechanism is a theoretical construct that refers to the intentional disavowing of information that

would cause anxiety or pain (cf. Freud, 1936/1984). Dissociation has commonalties with both repression and splitting. Freud viewed repression as a means to remove the conflict or pain from conscious awareness. Many theorists of the past used the terms repression and dissociation interchangeably (Kihlstrom & Hoyt, 1990). Splitting and dissociation both involve an active maintaining of distance between mental contents. They are used defensively to ward off anxiety but inadvertently contribute to a disturbance in identity or self (Tillman, Nash, & Lerner, 1984). Freud, Kernberg and Klein have used the term similarly. Splitting occurs when the individual is unable to reconcile contradictory feelings or urges which causes a division of self to accommodate the different views of reality. In this sense, dissociation is used to safeguard psychological integrity by protecting the individual from experiencing the entire reality at once.

An Overview of Dialectical Behavior Therapy (DBT)

Before the addition of treatment of dissociation can be addressed, it is first necessary to review the existing treatment of BPD that will be amended. The following is an overview of one of the most widely used treatments for BPD, Dialectical Behavioral Therapy (Linehan, Armstrong, Suarez, Allmon & Heard, 1991).

Origins of DBT

Dialectical Behavior Therapy (DBT) is an empirically researched treatment developed for individuals with self-harm behaviors, such as self-cutting, suicidal ideation and attempts. Many of these individuals meet the DSM-IV criteria for BPD. In developing DBT, Marsha Linehan (1993a) first attempted to treat individuals experiencing such problematic behaviors with standard cognitive behavioral therapy (CBT). She obtained poor results. The three particular problems with CBT that seemed the most troublesome were:

1. Clients receiving CBT found the continual focus on change to be invalidating. This often led to their abandonment of treatment, and/or anger at the therapist.
2. Therapists were unwittingly reinforced when they stopped pushing for change as a result of the client's anger, emotional withdrawal or threats. Therapists were also punished for effective treatment (i.e. a client attempts suicide when the therapist refused to hospitalize them and reinforce their suicidal threats).
3. Therapists were unable to address all that needed to be addressed. It was impossible to teach and strengthen new skills while targeting and treating the

client's suicidal behaviors and motivation from the previous week (Sanderson, 2003a).

These problems led Dr. Linehan and her research team to modify the treatment to produce better outcomes. They decided to alter the way they used CBT by adding strategies of radical acceptance and validation of the client's capabilities. The new emphasis on acceptance did not eliminate the emphasis on change; rather, the two enhanced each other. Linehan and her colleagues adopted the premise that clients are doing the best that they can for right now and need to change if they want a life worth living. It was the synthesis of acceptance and change within the treatment that led to including the term *dialectical* in the name of the treatment (Dimeff & Linehan, 2001).

The second modification of standard CBT was dividing the therapy into several different components. These were structured individual or group skills training, individual psychotherapy, and telephone consultation with the individual therapist. The third modification was the development of a consultation team meeting focused on keeping the therapist motivated and the treatment focused (Dimeff & Linehan, 2001).

Dialectics

The term dialectical was derived from classical philosophy. Sanderson, C. J. (2003b, p. 4) defined the term dialectic as "weighing and integrating contradictory facts or ideas with a view to resolving apparent contradictions." Dialectical strategies gave the therapist a way to balance acceptance and change in each session and helped the therapist and client avoid rigid thoughts, feelings and actions that occur in highly emotional treatment.

Dialectics involve several assumptions about the nature of reality: (1) everything is related to everything else; (2) change is constant and unavoidable; and (3) truth is found between the extremes. Sanderson (2003a) gave the following example as the way that these assumptions might be demonstrated in a DBT program:

> Suppose you are silent in groups. The other group members are affected by your silence and they try to get you to talk. You affect them and they affect you. Perhaps the group pushes you so hard that you feel like quitting and you talk even less. Then the other members get tired of your silence and withdraw. Paradoxically, this makes you feel better and causes you to talk a bit more. As you become a true member of the group, the leaders shift the way they run the group in order to manage the tension between you and the other members. In other words, you are all interconnected, influencing each other in each moment. (pp. 5-6)

Biosocial Theory

DBT is based on a biosocial theory of personality functioning in which BPD is seen as a biological disorder of emotional regulation. Linehan hypothesized that BPD arises from the transaction between *emotional vulnerability* and an *invalidating environment*. Emotional vulnerability is a heightened sensitivity to emotion, increased emotional intensity and a slow return to emotional baseline. This can be the result of *hard-wiring* or exposure to psychological trauma that predisposed one to chemical changes in the brain.

The term invalidating environment refers to a situation in which the personal experiences and responses of the child are invalidated or discounted by the primary

caretaker. The child's experience is not accepted as an accurate account of her true feelings (Sanderson, 2003b). An example of an invalidating situation is when a child says that they are thirsty and the caretaker says, "No, you're not. You just had something to drink." The child then learns that her internal experience is not what she thought it was; or, her experience of thirst has been invalidated.

Modes of Treatment

Dialectical Behavior Therapy consists of four modes of treatment. They are weekly individual psychotherapy, individual or group skills training, telephone consultation, and therapist consultation. Linehan developed all components to be used simultaneously.

Individual psychotherapy. In standard DBT, the individual therapist is the primary therapist. The therapist coordinates all aspects of the client's therapy, including involved psychiatrists and other mental health specialists. All other modes of therapy revolve around the individual therapy. The individual therapist is responsible for helping the client to integrate the skills that she learns, to adapt the maladaptive behaviors, and deal with any motivational issues and therapy-interfering behaviors.

Individual therapy usually takes place once a week and can range from 50-60 minutes to 90-110 minutes per session. The longer sessions are for those clients who have a difficult time opening up and then closing the session. It may be necessary to see the client twice a week in the initial stages depending on the severity of the issues being addressed (Linehan, 1993a).

Skills training. Linehan requires all clients to be in skills training for the first year of therapy. The addition of a skills training mode of treatment was one of the original

modifications Linehan and her research team made to standard CBT. They found that it was impossible to work on all of the skills deficits, in addition to intervention focused on crisis and other issues within a regular individual therapy session. Linehan also requires that any client in the skills training group must also be in weekly individual psychotherapy.

The weekly skills training group is conducted in a psychoeducational format. Linehan's groups generally are open groups that meet once a week for 2 to 2 ½ hours a session. It can also be done twice a week for an hour at a time. Linehan suggests that it is best to have the leader of the groups be someone other than the individual therapist, but this is not a requirement (Linehan, 1993a). The first hour of the group, or first group of the week, is usually spent reviewing the homework. The second hour, or second group of the week, is for teaching new material. Additional elements of the skills training group will be addressed later.

Telephone consultation. There are several reasons that telephone consultations are a part of the DBT program. First, many that have been diagnosed with BPD have an enormously difficult time asking for assistance in an appropriate and effective way. Some have a hard time because of feeling guilty or afraid, whereas others have no difficulty asking, but do so in an abusive or demanding manner. Telephone consultations are designed to assist the client in practicing the more adaptive ways of asking for help. Second, the clients need a way in which to generalize the skills that they have learned. The phone consult can be an opportunity to receive the coaching necessary to be able to put what they have learned into practice. Third, phone consultations allow the clients to

be able to mend any damage that they may have caused to the therapeutic relationship without needing to wait an entire week to do so.

Case consultation meetings for therapists. Working with clients diagnosed with BPD is enormously stressful for therapists. Burn out is a realistic problem that many therapists face. There are also many other therapist-interfering behaviors that need to be examined in order to promote therapeutic progress. For example, the group might examine if anyone is skipping the mindfulness practice at the beginning of the class, or starting the classes late. The case consultation meetings are also a place where problems that arise in the delivery of the treatment can be addressed. These meetings are held weekly. Therapists give the same one year commitment to the consultation group as the clients give to their skills training.

Ancillary treatments. There are other modes of therapy in which the clients may be engaged that need to be monitored by the primary therapist. They may include, but are not limited to, pharmacotherapy, day treatment, vocational counseling, and acute hospitalization.

Linehan's Assumptions about Borderline Clients and Therapy

The following are assumptions that the therapists use in their treatment planning and interactions with their clients (Linehan, 1993a):

1. Clients are doing the best that they can.
2. Clients want to improve.
3. Clients need to do better, try harder, and be more motivated to change.
4. Clients may not have caused all of their own problems, but they have to solve them anyway.

5. The lives of suicidal, borderline individuals are unbearable as they are currently being lived.
6. Clients must learn new behaviors in all relevant contexts.
7. Clients cannot fail in therapy.
8. Therapist treating clients diagnosed with BPD need support.

Client Agreements

The following conditions are a requirement to be accepted into DBT treatment (Linehan, 1993a). These are to be discussed and agreed upon within the first few sessions. A therapist need not push for a complete commitment as motivational issues and commitment strategies will be a regular part of the individual therapy work.

One year therapy agreement. The client must agree to remain in the skills training group for at least one year. The client and therapist are then able to reevaluate their continued participation once the year has elapsed. DBT has only one formal termination rule: clients who miss four sessions of scheduled therapy in a row, which includes skills training or individual therapy, must leave the program. At this point, they will not be allowed to reenroll until after the contracted period has expired. So clients that start and fall out of the program after four months into it must wait an additional eight months before returning to the program.

The therapist's commitment to treatment is not unconditional. Linehan (1993a) states that though it may be tempting to assure the client that the therapist will remain in the treatment for the entire time, there are reasons that can occur which may lead the therapist to terminate the agreement. Therapist termination may occur if the therapist finds that he or she is unable to help the client any further, or is pushed beyond his or her

limits by the client. In addition, the therapist may need to leave the current job or move out of town thus requiring termination. The therapist does agree to do his or her best to protect the client from unilateral termination. This includes alerting clients that they are in danger of termination and how they can amend their behavior to avoid it as well as assisting the clients in making the changes.

Attendance agreement. This agreement states that the client must attend all scheduled sessions and groups. Arrangements can be made to reschedule the sessions or group if it is convenient for both the client and the therapist. The therapist must explain that missing a group because of wanting to avoid a person in the group or a particular topic is unacceptable.

Suicidal behaviors agreement. If the client engages in suicidal behavior including parasuicide (self-harm without the intent to die) she should be advised that the primary goal of the treatment is to reduce this behavior. The agreement is that the client will work toward developing alternative ways to deal with the problematic issues and emotions that are currently leading the client to engage in these behaviors.

Therapy-interfering behaviors agreement. This agreement is to work on any problems that might interfere with the progress of therapy. Examples include missing sessions, not completing homework, burning out their therapist, and poor participation in group. These issues are targeted behaviors that are tracked. The use of diary cards, the device used to track targeted behaviors, will be explained in further detail later in this paper.

Skills training agreement. All clients involved in DBT treatment must participate in a one year skills training course. Arrangements can be made to teach this on an individual basis if there are no other ways to meet this requirement.

Research and payment agreement. Since outcome studies are an important part of conducting DBT, clients are informed and must consent to participation in the research conditions. Clients are also made aware of the fees and acceptable methods of payment.

Therapist Agreements

"Every reasonable effort" agreement. This is an agreement to conduct the therapy as competently as possible. Clients should be able to expect that their therapist will help them gain insight, learn and use new skills, and teach them behavioral tools that will assist them in dealing more effectively with their current situations and solving their own problems. This is also an opportunity to state what the therapist will not be able to do. Examples include taking away the pain, caring for them when they are able to care for themselves, or making everything better for the client.

Ethics agreement. This is an explicit agreement to obey all ethical standards and guidelines according to the therapist's professional code.

Personal contact agreement. The therapist agrees to come to all scheduled appointments and will cancel sessions in advance if necessary and will reschedule sessions when possible. Therapists will also discuss the way that back up coverage will be handled when they are required to go out of town. The therapist also agrees to provide reasonable telephone contact.

Respect-for-client agreement. The therapist agrees to respect the rights and integrity of the client.

Confidentiality agreement. The therapist agrees to keep all information shared in strict confidence with the general exclusions that are required by law (e.g. child abuse, homicidal threats, etc). Additional consent must be agreed upon regarding the sharing of videotapes, session notes and assessment materials. The client is informed that all information is shared within the treatment team and that other materials that are for research will not be identifiable.

Consultation agreement. Therapists must agree to attend regularly scheduled case consultation meetings with their supervisor, a peer supervision group, or other members of the client's treatment team. This assures the client that the therapist is willing to get help when needed and will engage in self-care.

Therapist Consultation Agreements

There are certain agreements that therapists make to one another as part of the consultation groups. These agreements involve following the DBT general guidelines. The agreements are to assist other therapists in remaining faithful to the DBT framework.

Dialectical agreement. The consultation group agrees to accept the dialectical philosophy that there is no absolute truth and to search for the synthesis between the polarities that emerge. This also is a means to deal with controversies that might arise within the consultation group that threaten to split the team.

Consultation-to-the-client agreement. The team members agree that they are not the intermediaries for the clients in dealing with the other therapists on the treatment team. Instead, the team members agree to consult with their own clients on how they might interact with the other therapists and not to tell the other therapists how to interact with their clients.

Consistency agreement. The job of the treatment team is not to provide a perfect environment for the client. This removes the opportunity for the client to deal with the way the real world works. Instead the team will agree that it is not necessary for all the team members to remain consistent with each other and teach things in the same way or agree on what is proper for therapy. Therapists can make their own rules for how to conduct therapy.

Observing-limits agreement. The consultation group agrees that everyone needs to observe his or her own personal and professional limits. In addition, the group agrees to accept the limitations of the individual therapists in the group.

Phenomenological empathy agreement. Therapists agree to look for phenomenologically empathic interpretations of the client's behavior instead of being pejorative. Therapists agree that clients are doing the best that they can and are not trying to play games or sabotage therapy.

Fallibility agreement. There is an explicit agreement that all therapists are fallible. There is no need to be defensive because this is agreed upon from the beginning. The task of the consultation group is to apply DBT to one another, to help each therapist stay within DBT protocols. When a therapist inevitably violates an agreement, the task of the consultation team is to point out the polarity and move to search for the synthesis.

Core Treatment Strategies

Linehan developed strategies for the therapist to use in achieving the goals of treatment. The two strategies that are central in the understanding and implementation of DBT are validation and problem solving.

Validation strategies. There are two types of validation according to Linehan (1993a). The first type involves the therapist finding the value or truth within the client's behavior, emotion, or cognition, and reflecting that back to the client. For example, if the client states that she feels like cutting her wrists, the therapist might reply, "I can see why you are in such pain. That would be difficult for anyone to handle". The second type has to do with the therapist's belief that the client is inherently able to build a life worth living. It is focusing on the strengths within the client and encouraging her to do so as well (e.g., "When you make up your mind to do something, you really follow through. You might want to use that to your advantage").

Problem solving strategies. Problem solving strategies focus on change. These strategies include performing a behavioral analysis of the targeted behavior, performing a solution analysis with behavioral solutions, orienting the client to the solutions, getting a commitment from the client to engage in the solution, and applying the treatment. A *behavioral analysis* is a moment-to-moment chaining of events to determine what prompted the problematic event, as well as a functional analysis to find any reinforcers for the maladaptive behavior. This behavioral analysis is used each time a targeted behavior occurs during the week prior to the session.

Special Treatment Strategies

Additional strategies were developed to deal specific circumstances that may be encountered during the course of treatment. The following are descriptions of these treatment practices.

Crisis Strategies. The responsibility for assisting the client during crisis belongs to the individual therapist. Other team members should refer the client back to the

individual therapist to ensure that the treatment plan is followed. Team members can assist the client in practicing her distress tolerance skills until the individual therapist is available.

Linehan suggests that the standard on-call procedures adopted by most agencies (where one therapist answers all calls for that week) is insufficient and does not take advantage of the therapeutic relationship. Instead, she has developed a checklist that is used by the client's therapist that has a predetermined format of which both client and therapist are aware. The checklist is a list of strategies or topics that the therapist uses to keep the call on track. The following are guidelines that are part of the checklist.

1. *Pay attention to the affect rather than the content.* The therapist should assist the client in identifying the feelings she is experiencing and provide validation for her experience. The therapist provides an opportunity for emotional ventilation and reflects back the overall emotional response.
2. *Explore the problem now.* It is common for BPD individuals to either forget the immediate precipitant to the current event or to generalize it to all of the times it has occurred over the past few weeks instead of looking at this instance. The therapist is to help her observe this one experience and focus only on the events since their last contact. The therapist can then assist the client in recognizing the precipitant to the event and can then begin to accurately define what the problem really is. Frequently BPD individuals will move directly to solving the problem before they even know what the problem is. This step is designed to make the solution better fit the problem.

3. *Focus on problem solving.* After the problem is identified, then solutions can start to be formulated. The therapist acts as a consultant. Suggestions and advice can be given to the client at this point to aid the decision about how to proceed. The suggestions given are based on the skills that the client has already learned or is in the processes of covering in skills training.

   After the decision to act is made, the therapist examines and discusses the possible consequences of the actions the client is planning to make. If there are any areas of the client's plan that seems contraindicated or unrealistic, they are directly confronted. It is important for the therapist to be direct as it is difficult to weigh pros and cons or look at alternatives when the client is in a state of emotional arousal.

   Once a plan of action has been developed, the therapist looks for any factors that may interfere with the client carrying it out. If factors are identified, then contingencies are addressed. The therapist reinforces any adaptive responses the client makes during the process.

4. *Focusing on affect tolerance.* While validating the anguish that the client is experiencing, the therapist discusses the necessity of being able to tolerate the negative affect. Linehan (1993a) suggests making statements such as, "If I could take away your pain, I would. But I can't. Nor, it appears, can you. I'm sorry for the pain you are in, but for the moment you have to tolerate it. Going through the pain is the only way out." (p. 467)

5. *Obtaining commitment to a plan of action.* The therapist should make every effort to get the client's commitment to the developed plan. This should include

the steps that she is going to take and any follow up that is necessary between that moment and the next scheduled contact.

6. *Assessing suicide potential.* The therapist reassesses suicide potential at the end of each crisis interaction. The therapist determines if the crisis has been resolved sufficiently that the client believes that she can refrain from acting on her prior impulses. If the client does not believe that she can remain safe, the therapist moves to the suicidal behavior strategies described next.
7. *Anticipate a recurrence of the crisis response.* The client will commonly experience a resurgence of the negative affect that led to the current crisis. The therapist can assist the client in structuring her time between the current contact and the next scheduled contact. The client should be warned that she will most likely experience aversive feelings and that she should plan for how to deal with them.

Suicidal Behavior Strategies. There are two tasks for the individual therapist to complete when responding to suicidal behavior. They are responding actively enough to block the client from harming or actually killing herself and responding in a way that reduces the chance of further suicidal behavior. The suicidal behavior strategies that Linehan suggests include assessing the frequency, intensity, and severity of suicidal behavior, conducting a chain analysis, discussing alternative solutions versus tolerance, focusing on negative effects of suicidal behavior, reinforcing nonsuicidal responses, obtaining commitment to a nonsuicidal behavioral plan, validating the client's pain, and relating current behavior to overall patterns. Suicidal behavior strategies should be implemented if any of the following four situations occur: (1) the client reports previous

suicidal behavior during an individual therapy session; (2) the client threatens imminent suicide or parasuicide (non-life-threatening acts of self-harm); (3) the client engages in parasuicide during the contact or contacts the therapist immediately after engaging in parasuicidal behavior; (4) the client reports or threatens suicidal behavior to a collateral therapist. These strategies assist the therapist to deescalate and assess the lethality of the situation.

Telephone Strategies. The overriding principle of DBT telephone strategies is that a client need not be suicidal to be able to obtain extra time and attention from her individual therapist. This is designed to minimize reinforcement for parasuicidal behavior. Second, telephone strategies were also developed to assist the client in generalizing acquired skills. Third, it provides an opportunity for the client to receive additional therapy to avoid or deal with crisis situations. Fourth, it teaches the clients how to ask for assistance in an appropriate and more effective way. The phone strategies used can differ according to the client's needs. The client that rarely uses the phone would be encouraged to ask for help at earlier stages in the crisis to learn how to avoid the crisis in the future. Excessive callers might be instructed to improve her distress tolerance skills. The telephone strategies are designed to assist the therapist in techniques to employ and issues to avoid in responding to a telephone consultation.

One strategy includes instructing the clients that they are expected to call their therapist before they engage in parasuicidal behavior and that they do not need to be suicidal to call. In fact, the rule is that the client may not call the therapist for 24 hours after a parasuicidal behavior has occurred (unless the injuries are life-threatening). The rationale is that the therapist can only help before the behavior takes place. The call is no

longer useful after the fact because the client has already used self-injury to solve the problem that she was experiencing. It is important that the therapist follow through with this rule in order to help shape the client in being able to access help before the crisis takes place.

Stylistic Strategies: Irreverent Communication

Irreverent communication strategies are used to push the client off balance so that rebalancing can occur. Irreverent communications can be used to get the client's attention, to shift the client's affective response, and to get the client to look at a completely different point of view (Linehan, 1993a). It is an offbeat style that requires a matter-of-fact or deadpan style. An example of an irreverent response to a client stating that they are going to kill themselves might be, "I thought you agreed not to drop out of therapy."

To be effective, irreverence has two components, it must be genuine, and it must be built on a foundation of warmth and compassion. Irreverent communication balances reciprocal communication, which is warm, empathic, and directly responsive to the client (Linehan, 1993a).

Stages of Treatment and Behavioral Targets in BPD

The overall goal of DBT is to help the client create *a life worth living*. It is designed to occur in stages. Each stage focuses on certain behavioral targets that are tracked and focused on in individual therapy. In the Pre-treatment Stage, the focus is on assessment, getting the client to commit to therapy, and orientation to the therapy. The focus of Stage 1 is on stabilizing the client which includes dealing with suicidal behaviors, therapy interfering behaviors and behaviors that interfere with the quality of

life. It also incorporates the acquisition of the skills necessary to work on these issues. Stage 2 deals with helping clients experience feelings without having to shut down by dissociating, avoiding life, or experiencing other symptoms of posttraumatic stress disorder. Stage 3 assists in building an ordinary life and solving ordinary life problems. Stage 4 focuses on self-esteem and resolving feelings of incompleteness. A more in-depth description of the stages follows.

Pre-treatment stage: Orientation and commitment. All potential skills training members should have one or more meetings with the skills trainer to decide whether the skills training group is appropriate and what it entails. The meeting should include a thorough assessment that includes diagnostic interviewing as needed to assess for BPD. There should also be a formal or informal assessment of the individual's psychosocial skills. In the next step, the trainer briefly presents the biosocial theory of BPD. The pre-treatment interview should include an orientation to the specifics of the skills training, how the group will function, and the client's and therapist's roles in treatment. The *diary card* is introduced at this point as well. A further explanation of how the diary card works will be discussed in Stage 1. If it is decided that the skills training group is appropriate, the therapist makes a commitment to work with the client. The therapist then works with the client to obtain commitment to the group. This is one of the most important aspects of the treatment and may need to be addressed throughout the therapy process. It is vital that the client commit at some level before beginning the group. An additional goal of this stage is to begin to develop a personal therapeutic relationship with the client.

Stage 1: Attaining basic capacities. The first stage of therapy focuses on suicidal and parasuicidal behaviors, therapy interfering behaviors, major quality-of-life-interfering behaviors, and skill deficits. These are the primary behavioral targets that will be tracked on the *diary card*, (Linehan, 1993a) that the client is expected to complete on a daily basis. In addition, the core mindfulness skills (addressed later) are tracked as well.

The diary card is completed every day and reviewed each and every week during Stages 1 and 2 to obtain information about relevant behaviors. The card can be used for a variety of purposes. Its primary purpose is to track parasuicidal behaviors and other high risk behaviors that threaten the success of the client in completing the treatment program. It tracks frequency, level of affect before and after the urge to engage in high risk behavior, skills used to manage emotions, and any actions taken. There is a hierarchy of targets that are tracked in DBT. These targets include suicidal behaviors, therapy-interfering behaviors, quality-of-life-interfering behaviors, and increasing behavioral skills. The targets are identified by the therapist and written on the diary card for the client to track throughout the week. The cards are then reviewed at the beginning of each session. If a card in not brought in or is incomplete, it is considered a therapy interfering behavior and is dealt with as such.

Stage 1 is one of the longest stages of treatment. It can take a year to even get close to controlling suicidal and therapy-interfering behaviors, the first two targets (Linehan, 1993a). The length of this phase can vary according to the client's commitment level and the therapist's ability to help the client integrate the skills learned.

Stage 2: Reducing posttraumatic stress. The second phase of treatment can only begin when the previous target behaviors are under control. Linehan (1993a) suggests

that the task of reducing posttraumatic stress remain as the second phase even though some consider BPD to be a form of posttraumatic stress. She states that the "uncovering" work that many therapists engage in therapy by discussing and exploring childhood abuse is frequently too much for the client to bear. The client becomes overwhelmed emotionally which increases self-harming behaviors, and, ultimately, makes them more emotionally dysregulated.

Linehan does not suggest ignoring the previous trauma. Instead she suggests looking at it in relation to the Stage 1 targets. If the client's flashbacks or memories are precipitants to suicidal behaviors, then they should be addressed as any problem that needs to be solved. They would most likely be targeted with the use of distress tolerance skills and mindfulness skills, discussed in more detail later. The main idea is that the prior trauma is not brought into therapy before the client can cope with the consequences of being exposed to it.

Stage 3: Increasing self-respect and achieving individual goals. This is the phase that focuses on developing the ability to trust one's self, validate one's own feelings and behavior and respect one's ability to be independent of the therapist. There is more of a weaning away from the reliance of the therapist that happens in this stage which involves learning to more independently make decisions and deal with life's situations. The client may frequently *take a vacation* from therapy during this stage and work more on regular daily issues now that she has the skills to do so. The client may also begin to set future goals and look at how she will start to live life outside of the therapeutic relationship. This is a necessary stage if the client is going to be able to successfully end what likely has become an intense therapeutic bond.

Stage 4: Resolving a sense of incompleteness and achieving joy. This stage was added later by Linehan (1993a) for those clients who feel existentially or spiritually unfulfilled. It is meant for those who wish to find more of a connectedness to a greater whole. This stage can also involve changing one's career path or seeking meaning through more spiritual means. Not all clients participate in this stage.

Skills Training Group

Skills training rules. Linehan (1993b) offers the following rules for the skills training groups. She suggests that the trainer thoroughly discuss the rules of the group during the first session. This gives the clients the basis on which their participation may be evaluated as well as an understanding what to expect. It also gives the trainer the opportunity to detect and confront any misconceptions. It is necessary to specify and obtain agreement from each client in the form of the treatment contract. There is an opportunity for the clients to engage in discussion during this process. It also gives the client a sense of control rather than being forced to adhere.

1. *Clients who drop out of therapy are out of therapy.* This is the same rule as the one described earlier. A client will be dropped from the program after the 4th missed session in a row. At that point, the client is not allowed to return to the program until the contracted time expires. Hence, if a client contracts for one year of participation and is dropped after the 4th month, they must wait an additional 8 months before returning.
2. *Each client has to be in ongoing individual therapy*
3. *Clients are not to come to sessions under the influence of drugs or alcohol.*

4. *Clients are not to discuss past (even if immediate) parasuicidal behaviors with other clients outside of sessions.* The reasons for this rule are several. First, the treatment focuses on decreasing the opportunity for reinforcement of behaviors that are to be changed. There is also a tendency for one parasuicidal event to trigger others in the group. This rule helps those who are trying to refrain from self-harm to not be activated by the discussion of it.
5. *Clients who call one another for help when feeling suicidal must be willing to accept help from the person called.* The client cannot just call someone stating that she is feeling suicidal if she is not open to receiving the help that the other is offering.
6. *Information obtained during sessions, as well as the names of clients, must remain confidential.*
7. *Clients who are going to be late or miss a session should call ahead of time.* This cuts down on the group worrying about the missing client's well-being. It also allows the trainer to know where the client is and that they need not hold up beginning the group.
8. *Clients may not form private relationships outside of training sessions.* This means that the clients who form relationships outside of the sessions must be able to discuss the relationships within the sessions. This allows either member of the partnership to be free to discuss any difficulties or issues that develop. One client, therefore, may not swear another to secrecy.
9. *Sexual partners may not be in skills training together.* The development of sexual relationships in group can occur. This rule informs those involved that one will

be required to leave and be reassigned to another group. This alleviates any difficulties that may arise when a relationship is dissolved and the two clients return to group.

Behavioral skills covered in skills training groups. Linehan (1993a) states that the nine criteria for BPD can be collapsed into five categories: self dysfunction (inadequate sense of self, sense of emptiness); behavioral dysregulation (impulsive, self-damaging, and suicidal behaviors); emotional dysregulation (emotional lability, problems with anger); interpersonal dysregulation (chaotic relationships, fears of abandonment); and cognitive dysregulation (depersonalization, dissociation, delusion). DBT targets these problem areas with behavioral skills. The skills fall into four categories: core mindfulness skills, interpersonal skills, emotion regulation skills, and distress tolerance skills.

Core mindfulness skills. Mindfulness has to do with a client learning to control her mind rather than allowing her mind control her. It is learning to direct her attention to one thing at a time in the moment. Linehan (1993b) describes mindfulness as the process of observing, describing, and participating in reality in a nonjudgmental manner, in the moment and with effectiveness. An example of this is when an individual is eating dessert and noticing every flavor in each taste instead of eating dessert while having a conversation and thinking about what one is going to say next, or seeing who else is in the room, or wondering if it was a bad idea to eat the dessert in the first place.

Mindfulness skills are the first skills taught and the first targets on the diary cards that clients fill out on a weekly basis as part of their homework. These are also the only skills that are highlighted throughout the entire year of skills training. They are

psychological and behavioral versions of meditation practices from Eastern mediation and Western contemplative practices (Linehan, 1993b).

DBT posits that there are three states of mind that an individual has. They are *reasonable mind, emotion mind*, and *wise mind.* A person is in *reasonable mind* when approaching things intellectually, rationally or logically. A person is in *emotion mind* when thinking and behavior is influenced by the current emotional state. *Wise mind* is the integration of *reasonable mind* and *emotion mind* and is the state of mind from which one wishes to function. It is a more informed and balanced state of mind. Another term for this state of mind is *being centered.* Mindfulness skills are the vehicles for balancing reason and emotion and achieving *wise mind.*

The mindfulness skills are broken down into *what* skills and *how* skills. *What* skills consist of observing, describing and participating. *How* skills include taking a nonjudgmental stance, focusing on one thing in the moment, and being effective. The first *what* skill, *observing*, is attending to events, emotions and other actions. It is allowing oneself to be aware of whatever is happening. The second skill, *describing*, is learning to apply verbal labels to environmental and behavioral events. It is learning to describe the target without allowing emotions or thoughts to confuse the description. For example, describing fear in a mindful way might include that one's stomach tightens or one's breath becomes shallower rather than saying one is tense or nervous. The third skill is the ability to *participate* without being self-conscious. It is the ability to stay in the event without separating oneself from the activity.

The first *how* skill is taking a *nonjudgmental stance.* This is being able to practice the *what* skills without deciding if it is good or bad or trying to determine the value of the

activity. The second *how* skill is learning to keep one's *focus on the activity* at hand rather than splitting their attention. This is staying in the moment rather than focusing on the future or past events. It is a difficult task for many but especially for clients diagnosed with BPD. The third skill is *being effective*. This skill emphasizes doing what is called for in that particular situation more than doing what is *right*.

Interpersonal effectiveness skills. Many of the skills taught in this module are similar to those taught in assertiveness classes. These include strategies for asking for what one needs, saying no, and coping with interpersonal conflict. This module also includes skills in keeping relationships and keeping one's self-respect (Linehan, 1993a).

Emotion regulation skills. BPD individuals have intense and labile emotions. Some of the skills taught in this module include identifying and labeling affect, identifying obstacles or changing emotions, reducing vulnerability to *emotion mind*, increasing positive emotional events, increasing mindfulness to current emotion, taking opposite action, and applying distress tolerance techniques.

Distress tolerance skills. Distress tolerance skills help to teach the client to learn to bear emotional pain skillfully. This is important because pain in life cannot be avoided. The inability to tolerate and accept pain in one's life increases the amount of suffering an individual experiences. These skills teach the client how to survive crises and accept life as it is in the moment. Some of the skills that are taught are distracting, self-soothing, improving the moment, and thinking of pros and cons. Acceptance skills include radical acceptance, turning the mind toward acceptance, and willingness versus willfulness.

How Dissociation Is Addressed Within DBT

Dissociation is considered a therapy-interfering behavior within DBT. Marsha Linehan's book and training manual (1993a, 1993b) suggest that the client use mindfulness skills to stay in the moment, and complete a behavioral analysis to better understand why and how she dissociates in order to alter the behavior in the future. Behavioral analysis is one of the strategies used to better understand a client's behavior. The purpose is to figure out what the problem is, what lead up to it, what is interfering with the successful resolution of the problem and what is available that will help solve the problem. It is a detailed analysis of the situation that includes the thoughts, feelings and actions of the client. Behavioral analysis is used for any problem or therapy-interfering behavior, like dissociation, to find out how it can be dealt with and avoided in the future.

Linehan teaches other skills in the Distress Tolerance module that are effective in decreasing dissociation, though not targeted for that purpose. Distress Tolerance Skills are designed to help the client survive crisis situations. Some of the skills included in this module are the use of imagery, relaxation and self-soothing. By using these skills, the client's stress level is decreased and their ability to tolerate stress increases, thus requiring less dissociation.

Linehan's proposed proactive means of regulating emotions might also indirectly address dissociation. These Emotion Regulation Skills focus on reducing emotional reactivity (a trigger of dissociation) by relieving physical and environmental stressors. The Emotional Regulation Skills include treating physical illness, balanced eating, avoiding mood-altering drugs, balanced sleeping, and exercise.

Efficacy of DBT in Treating Dissociation

Recent studies have shown that DBT has significantly reduced hopelessness, depression, anger, suicidal acts, frequency of parasuicidal behavior, and dissociation in patients diagnosed with BPD (Bohus, et al. 2000; Koons et al. 2001). However, after reviewing the outcome measures of the Koons et al. (2001) study, the results show something very different. The mean DES scores for the two groups were vastly different. The DBT group had a mean DES score of 22.3 at the beginning of treatment, which is considered below the pathological level, (or the level that would meet criteria for a comorbid dissociative disorder). The control group, however, had a mean DES score of 41, which has been shown to be in the pathological range of dissociation and frequently meets the criteria for DID. The study stated that 80% of the group with the lower level of dissociation did improve overall, which means that DBT can be effective with lower levels of dissociation. This study cannot comment as to the efficacy of DBT with more pathological levels of dissociation. The Bohus, et al. (2000) study also showed improvement in dissociative symptoms. The subjects in their study had a mean DES score (24.9) corresponding to lower levels of dissociation.

Criticisms in the Treatment of Dissociation Using DBT

As stated above, Linehan's (1993a, 1993b) proposed methods in treating dissociative symptoms appears effective for lower levels of dissociation. There is the possibility, however, that some of these methods could exacerbate dissociative symptoms in pathological levels of dissociation as mindfulness may trigger a more trancelike state. It would be important to assess the clients to determine how severely dissociative they are

and to determine if additional treatment is necessary, as DBT does not directly address pathological dissociation.

Linehan (1993a) states that working on posttraumatic stress symptoms (dissociative symptoms) should be done only after previous target behaviors are under control. However, this may not be possible with the number of active posttraumatic stress symptoms, as well as the derealization and depersonalization that can exist at higher levels of dissociation. The International Society for the Study of Dissociation, the premier organization in the research and treatment of dissociative disorders, (ISSD, 1997) also states that behavioral analysis, as skill that Linehan suggests for treating this therapy-interfering behavior, is not an effective method of treatment for higher levels of dissociation.

Hence, additional and more specific treatment interventions need to be developed and employed to assist clients in managing more pathological dissociative symptoms. The following suggestions are drawn from treatment done with dissociative disorders.

Proposed Additions and Augmentations to DBT to Address Dissociation

It is likely that the addition of five elements to the existing DBT framework would more adequately address dissociative features in BPD clients. In turn, this would improve the efficacy of the treatment overall as those clients with higher levels of dissociation would be more adequately grounded and thus more likely to be able to absorb and utilize the material and skills presented. The five elements are assessment, psychoeducation, safety and containment skills (including a more thorough development of an internal safe place and grounding techniques), fractionated abreactive work and communication/memory strategies. Further treatment considerations will be addressed in conclusion. Before these additions can be described, it is necessary to review the nature of dissociation.

The Nature of Dissociation

The DSM-IV (1994, p. 477) described dissociation as "a disruption in the usually integrated functions of consciousness, memory, identity, or perception of the environment. The disturbance may be sudden or gradual, transient or chronic". It has been traditionally understood as a defense mechanism to protect the self from overwhelming emotions or unbearable information (Paris, 2003). Dissociation can also be seen as a break down in the way information is processed (Bower & Sivers, 1998) possibly related to the release of large amounts of stress hormones and neurotransmitters during traumatic situations. This level of activation may interfere with the way information is processed (Paris, 2003).

Dissociation is often referred to as a creative survival technique because it allows the individual to endure hopeless, terrifying, or otherwise overwhelming circumstances,

yet resume relatively normal functioning afterwards. It begins to become dysfunctional only when the individual continues to use dissociation as their primary coping skill in absence of the original threat (Sidran Foundation, 2003).

Most clinicians treating clients with dissociative symptoms argue that dissociation exists on a continuum of severity. This has been supported by research (Braun, 1989; Brenner, 1994; Hilgard, 1977; Putnam, 1989; Ross, Anderson, & Fraser, 1992; Spiegel, 1986; Waller, Putnam, & Carlson, 1996). This continuum reflects a range of dissociative experiences. At one end are mild dissociative experiences that are common in the general population. These include daydreaming, highway hypnosis, or *losing yourself* in a book or movie. At the other extreme are more chronic and complex dissociative experiences, such as cases of Dissociative Identity Disorder (DID), formally known as Multiple Personality Disorder (MPD). Disorders such as depersonalization, derealization, acute stress disorder, and chronic posttraumatic stress disorder, fall between these endpoints.

As mentioned above, dissociation may not necessarily be pathological. Emergency workers and those who have to deal with trauma on a daily basis may employ dissociation as a coping mechanism. For example, Disaster workers report that they spontaneously invoke dissociative states by *switching off* their emotions or narrowing their focus to the immediate task on hand (Collins, 1997). This allows disaster workers to complete their duties and still maintain their emotional stability. Dissociation becomes pathological when it causes clinically significant distress or impairment in social, occupational, or other important areas of functioning (APA, 1994).

Assessment of Dissociation

Since the DSM-IV (1994) has added dissociative features within the criteria for BPD, and since dissociative processes interfere with the client's ability to benefit from DBT, it would be prudent to assess for the level of dissociation affecting each client. A screening device for dissociation should be administered to the client to determine if dissociative features are present and whether more though assessment is necessary. This screening process also provides the therapist and the client with basic information regarding the severity of dissociation present and will inform interventions in a manner to be described later.

The International Society for the Study of Dissociation (1997), recommends that a screening tool such as the Dissociative Experiences Scale – Revised (DES-R; Carlson & Putnam, 1993) be used. This tool can also be administered at predetermined times during the course of treatment to gauge treatment efficacy for dissociative symptoms. The psychometric properties of the DES-R are described in Appendix A.

The scores generated by this screening tool reflect the concept of dissociation as occurring along a continuum of severity. Possible scores range from 0 to 100. The median DES-R scores for normal populations is somewhere between 10 and 16. A score of 20 is used as the cut-off in most research studies and indicates dissociative symptom severity that may meet criterion for a disorder. A score of 30 and above is considered to be indicative of a pathological level of dissociation (Carlson & Putnam, 1993).

A factor analysis of the DES-R revealed clinically useful subscales within the tool (Ross, Ellason, & Anderson, 1995; Ross, Joshi, & Currie, 1991). The first factor, absorption-imaginative involvement, is composed of more common experiences, e.g.,

highway hypnosis or becoming engrossed in a movie to the point of not being aware of your immediate surroundings. The second refers to activities of dissociated states or amnestic experiences. This factor reflects experiences which the individual is later unable to recall. For example, the individual may find objects in their home or wardrobe that they do not remember purchasing, or are approached by people that they do not know who call them by another name or insist that they have met them before. The third factor includes depersonalization-derealization. Examples of depersonalization include the experience of feeling as though the individual is standing next to herself or watching herself do something. In derealization individuals have the experience of feeling that other people, objects, and the world around them are not real, or have the experience of being in a familiar place but finding it strange and unfamiliar (Beers & Berkow, 1999). These last two factors, activities of dissociative states and depersonalization-derealization tend be more powerful predictors of a dissociative disorder (Ross, Ellason, & Anderson, 1995; Ross, Joshi, & Currie, 1991).

It is recommended that any client receiving a score of 20 or higher be given a structured interview to assess for the presence of a comorbid dissociative disorder. Two such interviews include the Structured Clinical Interview for DSM-IV Dissociative Disorders – Revised (SCID-D-R; Steinberg, 1994) and the Dissociative Disorder Interview Schedule (DDIS; Ross, 1989). The psychometric properties of these structured interviews are described in Appendixes B and C.

Psychoeducation

Psychoeducation should begin directly after the client has been assessed. It is important to educate the client as to her level of dissociation, type of dissociation (e.g.,

absorption, derealization, depersonalization, and amnesia), etiology, nature and role of dissociative behavior, and prevalence. This serves to demystify and de-stigmatize perceptions of dissociation, and allows for a more accurate knowledge base and increased awareness of behavior within and outside of dissociative processes. This educative process most likely takes place throughout treatment as the client's understanding of herself and her dissociative symptoms will change as treatment progresses.

Etiology and prevalence of dissociation. Research has found that a history of childhood abuse is a common precursor for the development of dissociative disorders (Chu & Dill, 1990; DiTomasso & Routh, 1993; Draijer, 1994; Ensink, 1992; Kirby, Chu, & Dill, 1993; Putnam, Helmers, Horowitz, & Trickett, 1995; Ross, Miller, & Bjornson, 1991; Spiegel & Cardeña, 1991; van der Kolk & van der Hart, 1989; Zlotnick, Begin, Shea, Pearlstein, Simpson, & Costello, 1994). Although somewhat controversial, research posits that many individuals diagnosed with BPD also have histories of childhood abuse (Herman, Perry, & van der Kolk, 1989; Laporte and Guttman, 2001; Links, Steiner, Offord, & Eppel, 1988; Ogata et al, 1990; Paris, Zweig-Frank, & Guzder, 1994; Westen, Ludolph, Misle, Ruggins, & Block, 1990). It is no surprise then, that research has shown a high comorbidity between dissociative disorders and BPD; 35% - 71% of those diagnosed with DID meet criterion for BPD (Boon & Draijer, 1993; Braun & Sacks, 1985; Brodsky, Cloitre, & Dulit, 1995; Dell, 1998; Duffy, 2002; Ellason et al., 1996; Galletly, 1997; Gershuny & Thayer, 1999; Horevitz & Braun, 1984; Lauer et al., 1993; Lipsanen et al., 2004; Ross et al., 1990; Sar et al., 2003; Saxe et al., 1993; Scroppo, Drob, Weinberger, & Eagle, 1998; Stone, 2000; Tezcan et al., 2003; Tutkun et al., 1998; Wildgoose et al., 2000; Yargic, Sar, Tutkun, & Alyanak, 1998; Zanarini et al., 2000a;

2000b). It appears reasonable to assume then that DID (a severe manifestation of dissociative symptoms) is significantly present among those with BPD. Given this, dissociation should be more adequately addressed in recent treatment approaches and research related to those diagnosed with BPD.

Ross, Miller, and Bjornson (1991) assessed 484 adult psychiatric inpatients for dissociation over a two year period. The results indicated that dissociation, and dissociative identity disorder in particular, was more common in psychiatric inpatients than previously identified. Approximately 5% of those participating in the study met criteria for DID. The International Society for the Study of Dissociation and others suggest that DID may affect about 1% of the general population and 5-20% of psychiatric inpatients (Anderson, Yasenik, & Ross, 1993; Goff, Olin, Jenike, Baer, & Buttolph, 1992; Latz, Kramer, & Highes, 1995; McCallum, Lock, Kulla, Rorty, & Wetzel, 1992; Murphy, 1994; Ross, 1991; Ross, Anderson, Fleisher, & Norton, 1991; Saxe et al., 1993; von Braunsberg, 1994).

Safety and Containment

The development of treatment strategies for those with traumatic memories came from the work done with combat veterans. Therapists who worked with these survivors often noticed that such people experienced episodes of re-living the traumatic events from war. Sigmund Freud coined the term *abreaction* in 1892 to describe this experience of re-living traumatic events (Chefetz, 1997). These therapists found that assisting the veterans to abreact in a controlled environment brought relief and a decrease in their symptoms. They often used hypnosis as a means to help the veterans control the experience. Abreaction has also become a part of the treatment of memories of

childhood abuse and trauma. Since dissociative disorders often occur in response to traumatic childhood experiences, it follows then that abreaction would be an important part of the treatment of dissociative disorders (Braun, 1986; Chefetz, 1997; Fine, 1991; Kluft, 1991; Putnam, 1989; Ross, 1989; Turkus, 1991).

Because abreactive work can be traumatic and debilitating if the client has not developed the means to deal with the aftermath of experiencing intense emotions, it is important to first develop skills to contain the affect and keep the client safe before, during, and after the abreaction. Some of the most useful techniques have been derived from Kluft (1988, 1989) for use in preliminary interventions. Kluft calls these skills *temporizing techniques,* as they are developed to *buy time* by interrupting the processes that would normally overwhelm the client. Although he developed these techniques for use in hypnosis, they can be used outside of that process as well (Fine, 1991, 1993). The following are a few of the skills that may be helpful in treating clients with BPD and comorbid significant dissociative symptoms.

Development of an internal safe place. Kluft (1989) described the use of "the provision of sanctuary" (p. 94), or safe-place, as a necessary part of the treatment of dissociative individuals. These safe places are internal structures within the person's mind that can be used as a place to retreat or relax and gain strength (Grame, 1992). This serves two purposes: it decreases the client's level of distress, thus decreasing the need for the client to dissociate; and it gives the client a more proactive means of gaining control in regulating her affect, again decreasing the need to use dissociation to gain the same result. In the treatment of BPD individuals who also dissociate, this place of sanctuary is even more essential as their affect can become overwhelming very quickly.

Dolan (as cited in Shepard & Ferril, 1996, p. 58) developed the following approach to helping the client develop and access a safe place:

1. Ask the client to think of an (already identified) experience of comfort and security. Can be done with eyes opened or closed.
2. Direct her to notice and describe all the details of that experience with special reference to sights, sounds, and sensations.
3. Invite the client to take some time to enjoy that experience.
4. Then, after a moment, ask her to make any adjustments, additions and subtractions to that experience that would further enhance the safety and comfort of the experience.
5. Ask her to let you know when the experience is just right.
6. Invite her to enjoy the experience one more time and while doing this, she can select a souvenir or symbol of this experience that can serve to remind her of his [sic] safety and comfort. The souvenir can be any sight, sound or sensation that evokes the experience. Can let her unconscious mind chose the souvenir.
7. Ask the client to re-focus for a moment on the external reality of the present and then ask here [sic] to think of the symbol and notice the sensations.
8. Suggest to the client that she can feel free to use the symbol anytime she needs to reconnect with the feelings of safety and comfort.

This writer suggests prompting the client to adjust the experience to make it safer and to account for circumstances that the therapist may be aware of that may contribute to the client losing a feeling of safety. The therapist might prompt by asking direct questions such as, "What can you do to your safe place that will keep your mother out?"

(If in fact the client was afraid of her mother) or, "When you start to feel like cutting, how can you keep those feelings out of the safe place?" This allows the client to fortify the area and make it only accessible to herself or those parts of herself, if necessary, that are invited. It may also be necessary to develop more than one safe place to be utilized with different scenarios or different aspects within her (e.g., the more childlike aspects might feel more safe within a playroom setting while the more angry or violent aspects might be more comforted being in a room full of pillows). In addition, the therapist may assist the client in alternative or creative ways of dealing with the situations, (e.g., creating a force field that only she can cross or having the ability to convert any harmful item or person into a puddle until she has escaped). It may be necessary to adapt things on a continual basis in the beginning to cover all contingencies until the client is able to make changes on her own or no longer needs additional adaptations.

It should also be stressed that abusive or non-caring methods of safety are not appropriate in fortifying the safe place. For instance, having a guard posted outside the door of the castle is acceptable, but ordering him to stab anyone who tries to enter is not appropriate. It is also inappropriate to have herself placed in restraints to keep from harming herself or others. It is important that the client not be allowed to recapitulate the abuse perpetrated against her and that she be guided to find more viable ways of dealing with her fear and negative affect.

Development of temporizing techniques. Abreactive work can be traumatic if it is conducted too quickly, creating overwhelming experiences of fear and heightened stress levels if it is done too quickly. It is necessary for the client to learn ways in which she

can decrease the levels of anxiety and regain control of her affect. By doing so, the client decreases the likelihood of dissociating.

These skills are only as limited as the imagination of the client and the therapist. One such skill involves the use of an imaginary television and remote control. The therapist helps the client imagine that she is stepping backwards and notice that her memory is on a television screen. The client can then notice that the remote control for the television is next to her. She can pause the scene, stop the scene or adjust the scene in any number of ways. As the client becomes proficient in this technique, it may become possible to have her turn down the emotions and watch the scene again, or rewind and rewrite the scene as it could have happened if she were an adult with her present skills, (e.g., stand up to the person and tell them no and then call the police and have them arrested).

Containment of affect. It is often necessary to develop a way for the client to store affect or memories between sessions. This is often referred to as containing affect. These techniques can include storing the memories or affect in a time-locked safe that can be set to open only at the next session, or having the client imagine putting the affect in an actual container, duct taping the lid down, and storing them in the therapist's office. If the client does not feel comfortable that the affect will stay in the imagined container, the therapist can prompt the client for additional suggestions of how to make it more secure. This process should continue until an adequate solution is developed. By adequately containing the affect, the client will not be required to do so by dissociating.

Grounding techniques. Grounding techniques are used to help the client stay in the here and now. This is especially important when the client is beginning to feel as

though she is *slipping away* into a dissociative state. These are simple physical techniques that can be done in the moment and without any supplies. Examples include rubbing hands together, curling toes inside your shoes, gently pinching one's cheeks, doing jumping jacks, or anything that physically stimulates the client enough to interrupt the dissociation. Other grounding techniques that require planning might include holding ice cubes, smelling and applying lotion, or playing a song that is comforting.

It is important that the discussion about physical touch take place before it is used as a means to ground the client. Physical contact can trigger flashbacks of past abuse and, if inappropriate, breach professional boundaries. In general, physical contact should most often be avoided. However, there may be times when touch is necessary and useful, but only after the nature of the contact is discussed and the client has consented. Brief, non-intimate, non-intrusive contact, such as the therapist tapping the client's shoe with her own shoe may be enough to bring the client back into the here and now while maintaining appropriate professional boundaries.

Fractionated Abreaction

Once the client has learned some basic safety and containment skills, she will be able to begin processing traumatic memories. Richard Kluft (1996) stated that virtually all reports of the successful treatment of dissociative disorders, and DID in particular, include the *metabolizing* of traumatic memories (Braun, 1986; Fine, 1991; Kluft, 1991; Putnam, 1989; Ross, 1989; Turkus, 1991). As previously described, *abreaction*, or the expression and emotional discharge of traumatic material, is one technique used in treating clients with trauma histories. Kluft (1988, 1989) described the *fractionated abreaction* technique as a means to proportionately process the traumatic memories into

manageable amounts. This allows clients with less ego strength or people who are unable to participate in more intensive abreactive work to still process the traumatic memories. Fractionated abreaction involves deliberately interrupting abreactive events after a small amount of affect has been expressed and processing what has been recovered at great length. It is a careful, graduated exposure in the context of a safe therapeutic environment.

When possible, exposure is graduated according to the intensity of the memories, with less intense memories being verbalized, and desensitized before more upsetting ones are considered. In contrast to more strictly behavioral interventions, however, this approach does not adhere to a strict, pre-planned series of exposure activities. This is because the client's self-regulating abilities may be compromised, and her tolerance for exposure may vary considerably from session to session as a function of outside stressors, level of support, and internal containment (Briere, 1996).

It is important for the client to stay in the present as she works through the memories so that the exposure, and her processing of the material, is maximized. In this regard, the severely dissociative client may have little true exposure to her memories during her initial treatment, despite what may be detailed verbal renditions of a given memory. This is one of the reasons why additional sessions may be necessary when working with a highly dissociative client. She may need to process the same memory on different levels and numerous times before she is able to not only remain present during the abreactive experience, but remember it as well.

Different techniques can be used to slow down the process of abreaction, if necessary: imagery, breaking down the temporal sequence, and if the client is diagnosed

with DID, using alternate personalities that are more suited to dealing with the material. The client may be asked to begin to just think about one small aspect of the memory and then, as in systematic desensitization, rate their level of anxiety. Using various coping and containment skills that she has developed, the client begins to decrease her level of anxiety. She then can move to the next piece of abreactive work.

After memories have been processed without adverse impact, they can be lengthened or the emotional level connected to the memory can be titrated upward. Once clients learn that they can deal with the abreactive material and that the information can be contained in a safe manner, they become less apprehensive. Kluft (1996) argues that although the technique appears to go very slowly, the number of crises decreases as does the amount of time spent working with the client on stabilization. Kluft refers to this as "boring the patient into health" (Kluft, 1993, p. 145).

Communication/Memory Strategies

One of the problems with someone who dissociates is that she frequently is amnestic to the time and information acquired during the period of dissociation. Obviously this can be counterproductive if this occurs during therapy sessions. Hence, it is necessary for the individual to develop strategies to decrease the amount of information lost and increase her responsibility in retaining it. In addition, it may be necessary for the individual to learn ways to communicate within herself if the dissociation is more pathological, as it is in dissociative identity disorder.

The best strategies include augmenting skills that the client already utilizes. Simple strategies might include designating a certain place in the house to leave *to do*

lists, messages, and a journal. Breakdowns in keeping with the communication plan can be treated, as any therapy-interfering behavior would be in DBT.

Supplemental Treatment Considerations

These supplemental treatment considerations may assist the therapist in conceptualizing their client's level of dissociation with respect to Linehan's stages. Based on the theory that dissociation occurs along a continuum, supplemental treatment strategies will be proposed for use with clients exhibiting low, moderate, or high levels of dissociation. Clients with low levels of dissociation exhibit low levels of resultant dysfunction; clients with higher levels of dissociation exhibit higher levels of resultant dysfunction. It is common for clients to vacillate among the different levels of dissociation and the resultant dysfunction depending on their environment, treatment progress, and skill level. These considerations will be addressed in the sections below. A summary is offered in Table 2.

Lower levels of dissociation. This level incorporates more of the absorption aspects of dissociation, or for those clients that have developed, and are using, the skills taught for coping with dissociation. The general DBT skills of mindfulness and distress tolerance would satisfactorily meet the needs of the client. DBT as usual as presented by Linehan (1993) is an appropriate means of addressing this level of dysfunction.

Moderate levels of dissociation. Moderate symptoms would consist of both the depersonalization and derealization forms of dissociative experiences, chronic posttraumatic stress disorder and some amnestic experience. These symptoms will likely be at an Axis I level of dysfunction. Moderate levels differ from higher levels of dissociation in the level of intrusion and the ability of the client to function in daily

activities. A client experiencing a moderate level of dissociation would most likely still be able to participate in their regular daily routine although she experiences frequent intrusions (especially with increased stress levels).

While self-soothing and distress tolerance skills may need to be rehearsed and emphasized to ameliorate dissociative symptoms, they may not be enough to facilitate symptom relief. The techniques used to develop an internal safe place, temporizing techniques, and containment of affect are critical elements in treatment at this level. More time will be spent in skills training for these clients, and abreactive work will begin as soon as the memories become intrusive. Behavioral analysis of the events to locate triggers and target needs may assist in decreasing the incidents of dissociation, though only with less emotional material. Longer sessions may be required with more planned telephone conferencing for the client to check in, ground herself, and receive prompts from the therapist the client to practice the skills between sessions.

Abreactive work, which Linehan (1993a) suggests begin in Stage 2, must commence as dissociative symptoms surface rather than wait for the acquisition of skills. Intrusive memories, lost time, and depersonalization or derealization can not only interfere with treatment but also cause clinically significant distress or impairment in important areas of functioning. The therapist should use the fractionated abreaction techniques in dealing with the traumatic memories.

High levels of dissociation. High levels of dissociation are characterized by comorbid diagnoses of DID or DDNOS. The dissociative symptoms are much more frequent and cause extensive difficulties in daily functioning. It is recommended that individual therapy take place at least twice a week when the client experiences this level

of dissociative symptomatology. The increase serves a few purposes: the therapy provides more coaching opportunities and reteaches the skills learned during more dissociated states, provides an *external* safe place where the client can gain sanctuary, provides an opportunity to fortify containment of affect, and may serve as a means to prevent hospitalization. It is also an additional opportunity to work on fractionated abreaction, a very slow process. If the client is experiencing numerous intrusive memories, more time will be needed to get through the material. Self containment and safety skills are emphasized and communication and memory strategies will need to be discussed.

Additional communication skills necessary for those with a comorbid diagnosis of DID, include getting a consensus of the alter personalities, a component of DID, or aspects of the individual to agree on a method of communication. If there is an alter personality that has access to more of the system than others, they could be the conduit in which all of the alters check to gain consensus.

The main focus of the therapy, for BPD clients with comorbid DID or DDNOS is achieving a sense of integration or cohesion. Integration does not mean the eradication of alter personalities. Instead, integration may be seen as the ability to access all aspects of the person's memory, emotions and actions. It is an increased sense of connectedness and relatedness. Consultation with experts in treating dissociative disorders and special training will be needed if the therapist has not treated clients with these disorders before. It may be prudent to have regular supervision with an expert and invite the expert to attend the therapist consultation group for an in-service. Serious consideration should be given in referring the client if her symptoms are outside of therapist's scope of practice.

Table 2

Treatment recommendations for corresponding level of dissociation

Level	Possible dissociative symptoms	Techniques employed	Corresponding DBT module/stage
Low	Absorption Some depersonalization Some derealization PTSD - Infrequent flashbacks	**Assessment/psychoeducation***	Pretreatment stage
		Core mindfulness Emotion regulation Distress tolerance Behavioral Analysis	Skills building group reinforced in individual therapy
Medium	Absorption	**Assessment/psychoeducation**	Pretreatment Stage
	Chronic PTSD Axis I Depersonalization Axis I Derealization Some amnestic experiences	Techniques for Low level plus **Internal safe place** **Containment of affect** **Temporizing techniques** **Grounding techniques**	Skills building group reinforced in individual therapy
		Fractionated abreaction as memories intrude	Individual therapy in Stage 1
		Consultation with dissociation expert	**After assessment complete** Therapist consultation group
High	Axis I Dissociative Disorder NOS Axis I Dissociative Identity Disorder Chronic PTSD	**Assessment/psychoeducation**	Pretreatment Stage
		Emotion Regulation Distress Tolerance **Internal safe place** **Containment of affect** **Temporizing techniques** **Grounding techniques**	Skills building group reinforced in individual therapy
		Fractionated abreaction as memories intrude	Individual therapy in Stage 1
		Consultation with dissociation expert **Consider referring client to expert in dissociative disorders**	**After assessment** Therapist consultation group

* Bold type indicates proposed additions.

Concluding Remarks

Dissociative symptoms appear to be an intrinsic aspect of BPD (Zanarini, Gunderson, & Frankenburg, 1989, 1990; Zweig-Frank, Paris, & Guzder, 1994a, 1994b). Research is beginning to show that those diagnosed with borderline personality disorder are likely to experience dissociative symptoms (Table 1), and are more likely to

Cloitre, & Dulit, 1995; Zweig-Frank et al., 1994a, 1994b). Additionally, the American Psychiatric Association states that dissociation needs to be addressed in the treatment of those with BPD (Oldham et al., 2001).

Research indicates that Linehan's DBT is an effective treatment for BPD symptoms. DBT addresses dissociative symptoms indirectly and the efficacy research has been restricted to those BPD clients with lower levels of dissociation. This project has proposed and described new module of treatment to add to DBT which specifically addresses those BPD clients that experience dissociative symptoms ranging from low to high levels. Further research needs to be conducted to verify the clinical and empirical advantages of the enhanced DBT.

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Appendix A

Dissociative Experiences Scale-Revised (DES-R; Carlson & Putnam, 1993)

The Dissociative Experiences Scale – Revised (DES-R, Carlson & Putnam, 1993) is a 28 item self-report measure of dissociation that inquires about the frequency of amnestic experiences, gaps in awareness, depersonalization (distortions in perceptions of oneself), derealization (distortions in perceptions of one's environment), absorption, and imaginative involvement (Bernstein & Putnam, 1986). The respondent circles statements on a 10-point scale ranging from 0, labeled as *never*, to 10 labeled as *always*. The total score is equal to the mean of all item scores (i.e., scores range form 0-10).

Studies of the scale's reliability showed that the scale has good internal consistency and that scores on the scale are consistent over time. Studies of the internal consistency of scores have yielded split-half reliability correlation coefficients ranging from .83 to .93 (Bernstein & Putnam, 1986; Pitblado & Sanders, 1991). Another study of internal consistency of scores yielded a Cronbach's alpha of .95 (Frischholz, Braun, & Sachs, 1990). Test-retest reliability for the scale has been studied by administering the measure to subjects on two different occasions (about 4 weeks apart). Correlations between scores on the first and second administrations have ranged from .84 to .96 in various studies (Bernstein & Putnam, 1986; Carlson & Rosser-Hogan, 1991; Frischholz et al., 1990; Pitblado & Sanders, 1991). Studies of both internal and test-retest reliability have included subjects from clinical populations that show high levels of dissociation.

Appendix B

The Structured Clinical Interview for DSM-IV Dissociative Disorders-Revised (SCID-D-R; Steinberg, 1994)

Reliability. Numerous investigations, both in the United States and abroad (using Dutch, German, Norwegian, and Turkish translations of the SCID-D), have reported good to excellent interrater and test-retest reliability and very good discriminant validity of the SCID-D for the assessment of dissociative symptom severity and for the dissociative disorders in a variety of populations (Boon & Draijer, 1991; Goff, et al, 1992; Steinberg, Rounsaville, & Cicchetti, 1990). The SCID-D field trials conducted by Steinberg, Rounsaville, and Cicchetti utilized a test-retest reliability design, blind examiners, and a sample consisting of 141 psychiatric patients to examine both interexaminer and temporal reliability of the SCID-D over three time periods (baseline, at 2 weeks, and at 6-month follow-up). The range of weighted kappas, for both the presence and extent of dissociative symptomatology, was between very good and excellent (.77-.86) for each period (baseline, 2-week and 6-month follow-up). Interexaminer agreement levels for the type of dissociative disorder also ranged between very good (. 72) and excellent (. 86). Test-retest reliability analyses indicated very good reliability for the total overall assessment of the presence of a dissociative disorder (kappa = .88).

Discriminant validity. Numerous investigations have reported that the SCID-D-R is effective in distinguishing between patients with clinically diagnosed dissociative disorders and other psychiatric disorders (Boon & Draijer, 1991; Goff et al., 1992; Steinberg, Cicchetti, Buchanan, et al., 1994; Steinberg, et al., 1990). These investigations found that subjects receiving SCID-D diagnoses of a dissociative disorder had

significantly higher dissociative symptom severity scores and total SCID-D scores than subjects with other psychiatric disorders. In addition, the range, severity, and nature of the five dissociative symptom areas can assist clinicians in distinguishing between individuals with dissociative disorders and individuals with other psychiatric disorders.

Investigators have also noted that the SCID-D is able to distinguish between patients with seizures and pseudoseizures based on clinician diagnosis and electroencephalogram (EEG) (Bowman & Coons, 2000). Last, in addition to the SCID-D's ability to statistically discriminate between dissociative and nondissociative subjects, analysis of patient responses to SCID-D items reveals elaborate descriptions of dissociative experiences that provide useful diagnostic and therapeutic information. For a complete review of the diagnostically discriminating features of each of the five dissociative symptoms, see The Interviewer's Guide to the Structured Clinical Interview for DSM-IV Dissociative Disorders-Revised (Steinberg, 1994).

Appendix C

Dissociative Disorders Interview Schedule (DDIS; Ross, 1989)

The DDIS (Ross, 1989) is a 131-item structured interview schedule linked to the *DSM-III* that allows for the diagnosis of all five dissociative disorders, and major depression, substance abuse, and BPD. Additional items provide information about previous psychiatric history (hospitalizations, psychiatric medications, number of therapists), childhood physical and sexual abuse, dissociative symptoms, and First Rank Schneiderian (FRS) symptoms (i.e. , experiences in which entities or forces not acknowledged as part of the self are felt to act on the individual, such as believing that one's thoughts, feelings, or actions are controlled by others, hearing voices, etc.; Ross, 1989). The DDIS has an overall interrater reliability of 0.68; it has a specificity of 100% and a sensitivity of 90% for the diagnosis of DID (Ross, 1989). Following the procedure used by Sandberg and Lynn (1992), we slightly abbreviated the DDIS to exclude the sections concerning somatization and paranormal experiences.