A Closer Look at Dissociative Experiences in Borderline Personality Disorder (BPD)

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Outline of Tonight's Presentation

1. Review of BPD
2. Review of Dissociation
3. Description of our recent research
4. Dissociation in BPD
5. An Aetiological Explanation
6. Screening, Assessment and Treatment

What I would like you to take away

(1) Dissociation is **common and severe** in BPD
(2) Most clinicians do not have a good understanding of this, or how to identify and manage it
(3) This is an important problem because BPD places a huge burden on society
(4) …adding dissociation increases this burden
(5) One way to understand dissociation in BPD is through the lens of **attachment** and **trauma**
(6) Formulating BPD + dissociation in this manner can inform appropriate screening, assessment & treatment

Discussion Questions

1. Do you assess for dissociation in BPD?
2. What types of dissociative symptoms have you noticed most commonly accompany BPD?
3. How are BPD and dissociation related?

BPD

- Prevalence
- Burden
- Diagnostic Criteria

Prevalence of BPD

+ 1-4% in the general population
+ > 20% psychiatric outpatients
+ 43% psychiatric inpatients
+ 9% DEM presentations

Cost of BPD

- Cost per patient per year estimated at between USD$90,000 and $105,000 excluding community services
- Australian community sample of 4,579 full-time employed Australians, PD accounted for a loss of > AUD$4m work impairment days annually (greater economic burden than mood/anxiety combined)

  Loss of AU$1.5 billion per year (excludes non full-time employees)

BPD Diagnostic Criteria

1. Frantic efforts to avoid real or imagined abandonment
2. A pattern of unstable and intense interpersonal relationships characterised by alternating between extremes of idealisation 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
5. Recurrent suicidal behaviour, gestures, or threats, or self-mutilating behaviour

BPD Diagnostic Criteria

6. Affective instability due to a marked reactivity of mood
7. Chronic feelings of emptiness
8. Inappropriate, intense anger or difficulty controlling anger
9. **Transient, stress related paranoid ideation or severe dissociative symptoms**

Criterion 9 in DSM-5

"Transient, stress related paranoid ideation or severe dissociative symptoms"

+ Specifically refers to depersonalisation (p. 666)
+ Not discussed as a differential diagnosis (p. 666)
+ Not listed as a common comorbid condition (p. 665)
+ Narrow conceptualisation and diminished importance
+ At odds with a wealth of clinical and research data spanning 30+ years: dissociation in BPD is heterogenous, not always a reaction to stress, and often frequent

Dissociation

- Conceptualisation
- Nonpathological and Pathological Dissociation
- Dissociation in BPD

Dissociation

- First recognised as a clinical entity in 19th century
- Systematic scientific attention not given until 1990s
- Vague definition in the DSM-5: *"disruption of and/or discontinuity in the normal integration of consciousness, memory, identity, emotion, perception, body representation, motor control, and behavior"* (p. 291)
- Continued debate regarding aetiology, characteristics, scope and validity

Nonpathological Dissociation

+ Absorption / imaginative involvement

  "*a 'total' attention, involving a full commitment of available perceptual, motoric, imaginative and ideational resources to a unified representation of the attentional object*" (Tellegen & Atkinson, 1974)

  e.g., driving in a car and not remembering the trip

+ Normative/common experience, natural variation of consciousness, multidimensional trait, varies across general population, not necessarily related to trauma, related to hypnotisability

+ *Can be* adaptive – increases capacity for empathy, attunement, improved ability to attend to tasks without distraction, heightened sense of / fascination with reality, enabling greater creativity and peak experiences

Nonpathological Dissociation

- Highly correlated with pathological dissociation, dissociative disorders and psychopathology
- Facilitates development and maintenance of pathological dissociation
- *"absorption is to pathological dissociation as diabetes mellitus is to diabetic retinopathy"* (Dalenberg & Paulson, 2009, p. 150).

Pathological Dissociation

- Categorical (not dimensional), characterised by five features (as per Structured Clinical Interview for DSM-IV Dissociative Disorders [SCID-D]):
  1. **Amnesia** – a specific block of time of time has passed but not remembered
  2. **Depersonalisation** – detachment from oneself
  3. **Derealisation** – one's surroundings feel unreal, strange, or unfamiliar
  4. **Identity confusion** – uncertainty, perplexity or conflict about one's identity
  5. **Identity alteration** – objective behaviour reflecting different identities

Nonpathological v Pathological Dissociation

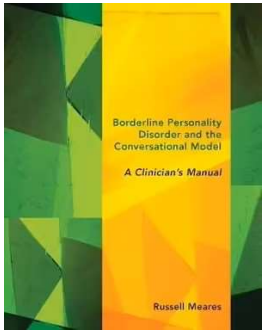
Nonpathological Dissociation	• Absorption • Imaginative Involvement
Pathological Dissociation	• Amnesia • Depersonalisation • Derealisation • Identity Confusion • Identity Alteration

Another Way to Categorise Pathological Dissociation

Holmes et al., (2005)'s Model of Dissociation

1. **Detachment** - the sense of being separate to one's body, the self and/or the external world (primarily *depersonalisation/derealisation* – Lanius et al., 2010)
2. **Compartmentalisation** - the inability to access stored information (also labelled *division of the personality* - van der Hart, Nijenhuis, & Steele, 2006)

Note. Russell Meares re-names compartmentalisation "secondary dissociation" and detachment "primary dissociation" in his discourse on dissociation and BPD



Function of Pathological Dissociation

+ Enhance chance of survival under overwhelming and / or traumatic conditions
+ Ability to narrow attentional focus and dampen potentially disorganising emotions enhances likelihood of rational decision making and effective action
+ Neuroimaging: during dissociation the medial prefrontal cortex inhibits processing of external emotional stimuli in the amygdala
+ Long-term sequestering of disturbing material prevents intrusion upon normal-life-self to enhance functioning
+ Traumatic experiences remained non-realised

DSM-5 Dissociative Disorders

1. Dissociative Identity Disorder (DID)
2. Dissociative Amnesia (DA)
3. Depersonalisation/Derealisation Disorder (DDD)
4. Other Specified Dissociative Disorder (OSDD)
5. Unspecified Dissociative Disorder (UDD)

1. Dissociative Identity Disorder

A. Disruption of identity with ≥ 2 personality states; discontinuity in sense of self / agency; alterations in affect, behavior, consciousness, memory, perception, cognition, and/or sensory-motor functioning. Observed by others or self-report.

B. Recurrent gaps in recall of everyday events, important personal information, and/or traumatic events (not ordinary forgetting).

C. Clinically significant distress or impairment.

D. Not part of cultural/religious practice, not attributable to physiological effects of substance or another medical condition.

2. Dissociative Amnesia

A. Inability to recall important autobiographic information (usually traumatic), not ordinary forgetting.

B. Clinically significant distress / impairment.

C. Not attributable to substances or neurological / medical condition.

D. Not better explained by DID, PTSD, acute stress disorder, somatic symptom disorder, or neurocognitive disorder.

Specify if with fugue (travel associated with amnesia)

3. Depersonalisation/Derealisation Disorder

A. *Either* **depersonalisation**: unreality / detachment to own thoughts, feelings, sensations, body, actions; *and/or* **derealisation**: unreality or detachment from surroundings.

B. During depersonalisation/derealisation, reality testing remains intact.

C. Clinically significant distress or impairment.

D. Not attributable substances or other medical condition.

E. Not better explained by schizophrenia, panic disorder, MDD, acute stress disorder, PTSD or another dissociative disorder.

4. Other Specified DD (OSDD)

+ Symptoms characteristics of DD but not meeting full criteria
+ Reason for not meeting criteria is specified, e.g.
+ Chronic / recurrent syndromes of mixed dissociative symptoms
+ Identity disturbance due to prolonged / intense coercion
+ Acute dissociative reactions
+ Dissociative trance

5. Unspecified DD

+ Symptoms characteristic of DD but not meeting full criteria
+ Reason for not meeting criteria not specified, or
+ no information exists to make a more specific diagnosis

My Research

Dissociative experiences among individuals with BPD receiving treatment in a community mental health service: Nature, severity and impact on DBT outcomes.

Research Questions

+ Extent and variation of dissociative experiences among individuals with BPD in the local context
+ Extent of overlap between dissociative experiences and borderline personality symptoms
+ Impact of dissociative experiences on DBT treatment outcomes

Predicted Outcomes

+ Dissociation in the sample would reflect that found in pre-existing literature (1/3 mild, 1/3 moderate, 1/3 severe)
+ There would be a small to moderate correlation between dissociative experiences and borderline symptoms; and
+ High scores on dissociative experiences would be associated with poor treatment outcomes after controlling for the severity of pre-treatment borderline symptoms.

Rationale for Research (existing literature)

- Dissociation increases risk and acuity and is highly prevalent in BPD…but
- Not routinely assessed for, despite…
- High levels of dissociation related to poorer treatment response e.g., DBT, Schema Focused Therapy, Transference Focused Psychotherapy, Short-Term Psychodynamic Group Therapy (Arntz et al., 2015; Kleindienst et al., 2011; Kleindienst et al., 2016; Spitzer et al., 2007)
- E.g., DBT positions dissociative experiences as **short-lived** and **uncommon,** categorised as a form of cognitive dysregulation "***cognitive diversion tactics***" (p. 351) or nonattentive therapy-interfering behaviour "***forms of avoidance***" (p. 76), (Linehan, 1993)

Participants and Procedure

- Adults with BPD receiving outpatient DBT at PAH, RBWH, TPCH, Logan Hospital (2017-2020)
- Assessed with the BPD-SI (BPD-Severity Index (v4) Structured Interview) (Giesen-Bloo et al., 2010)
- N=65 completed full pre-treatment measures
- N=18 completed 6 months of treatment and post-treatment measures
- 94.1% female, mean age 30.61 years (SD = 10.03, range 19.00 – 52.00)
- 4 weeks precommitment plus 6 months standard treatment (skills training groups, weekly therapy, phone coaching)
- Questionnaires completed at baseline and after each module (Distress Tolerance, Emotion Regulation, Interpersonal Effectiveness)

Two Principal Outcome Measures

1. Dissociative Experiences Scale, version 2 (DES-II) (Carlson & Putnam, 1993)
2. Borderline Symptom List, 23-Item Version (BSL-23) (Bohus et al., 2009)

Dissociative Experiences Scale

1. Dissociative Experiences Scale, version 2 (DES-II) (Carlson & Putnam, 1993)
   - 28 items, scored from 0% (never occurs) to 100% (occurs all the time), total score is overall mean (range 0-100) with ≤ 10 considered low, 11-29.9 considered moderate and ≥ 30 considered high. 3 subscales
     1. Amnesia *e.g., finding drawings etc you don't remember doing*
     2. Depersonalisation / derealisation, *e.g., feeling your body doesn't belong to you*
     3. Absorption / Imaginative Involvement *e.g., so absorbed in tv you are unaware of other events happening*
   - Dissociative taxon – subset of 8 items measuring **pathological dissociation**

Two Principal Outcome Measures

2. Borderline Symptom List, 23-Item Version (BSL-23) (Bohus et al., 2009)

   E.g. "*I thought of hurting myself*" and "*My mood rapidly cycled in terms of anxiety, anger, and depression*"

   - Experiences over past week, scored on a 5-point Likert scale from 0 (not at all) to 4 (very strong)
   - **4 items relating to dissociation were removed, leaving 19 items**

"I was absent-minded and unable to remember what I was actually doing,"
"I felt as if I was far away from myself"
"I felt disgust" (as an intrusion)
"I suffered from voices and noises from inside or outside my head").

BPD Scores in Our Study

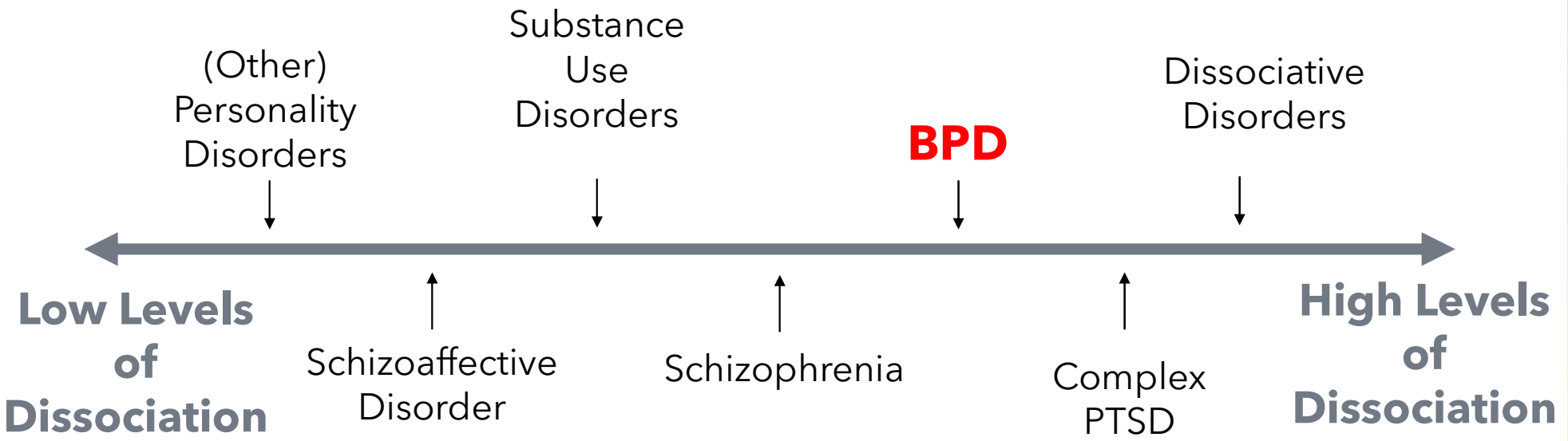
Measure	M	SD
BPDSI-IV Semi-Structured Interview (cut-off = 15)	36.20	10.27
Pre-treatment BSL-23 (extremely high)	64.94	15.28
Post-treatment BSL-23 (very high)	56.33	17.80

BPDSI-IV = Borderline Personality Disorder Severity Index v4 (Giesen-Bloo et al., 2010)
BSL-23 = Borderline Symptom List (Bohus et al., 2009)

Dissociation in BPD

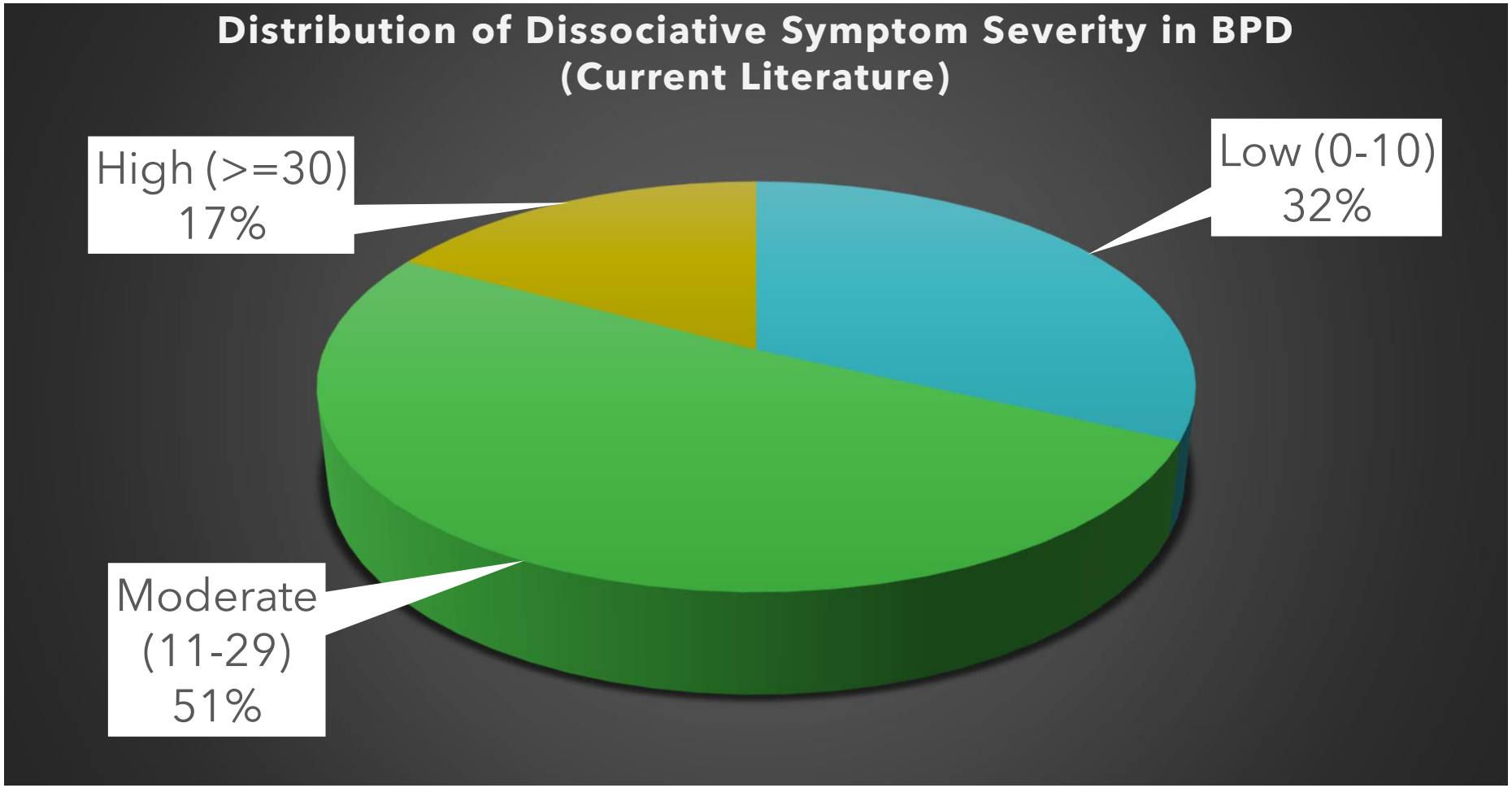
Extent and distribution of dissociation in BPD

Severity of Dissociation in Various Mental Health Conditions (Scalabrini et al., 2017 meta-analysis)



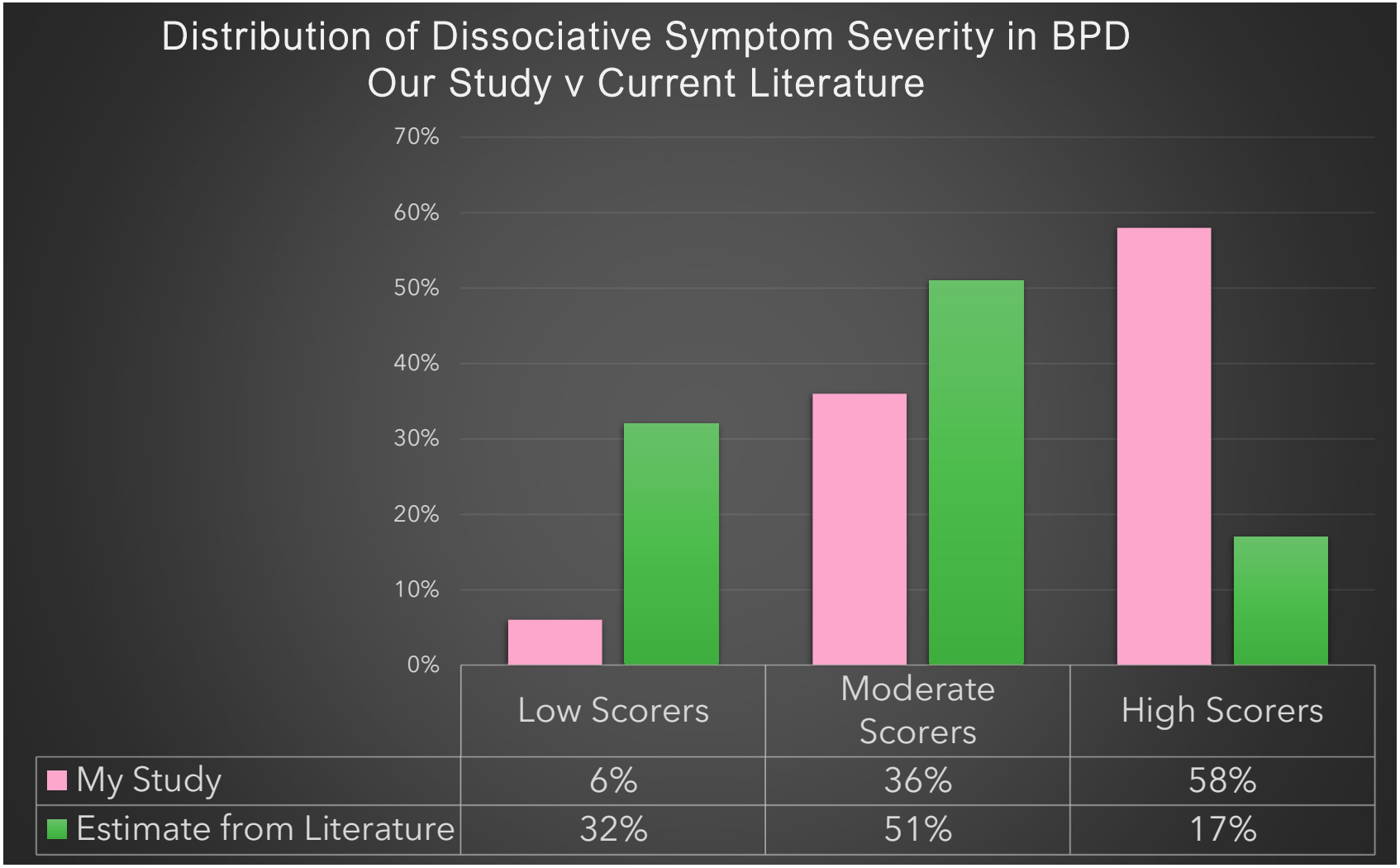
Extent of Dissociation in BPD (from literature)

- 2/3rds report pathological dissociation
- Strong positive correlation between scores on dissociation and trauma history / disorganised attachment
- Compared to BPD alone, BPD + dissociation → worse functioning
  - Higher levels of comorbidity
  - More frequent and longer hospital stays
  - Greater impulsivity
  - Higher rates of self-injury and behaviour problems
  - Increased risk of suicidality
  - Greater impairments on neuropsychological and adaptive functioning


Distribution of Dissociative Symptom Severity in BPD
(Current Literature)
High (>=30)
17%
Low (0-10)
32%
Moderate
(11-29)
51%

Distribution of DES-II Scores in Our Study

		M	SD	Range
Full-scale DES-II		36.92	19.34	6.07 – 82.86
Dissociative Taxon (score > 20)		30.58	21.90	
	%			
"Low" overall DES-II score	6.1			
"Moderate" overall DES-II score	36.4			
"High" overall DES-II score	57.6			
Beyond dissociative taxon threshold (score > 20)	63.6			


Distribution of Dissociative Symptom Severity in BPD
Our Study v Current Literature
70%
60%
50%
40%
30%
20%
10%
0%
Low Scorers
Moderate Scorers
High Scorers
My Study
6%
36%
58%
Estimate from Literature
32%
51%
17%

Interpretation of Our Results

- Going by total DES-II score
  - 1/3 have a dissociative disorder
  - Half have DID
  - 90% diagnosed with a dissociative disorder
- Going by dissociative taxon
  - 65% diagnosed with a dissociative disorder
- Spurious result? DES II is a screening tool only

Comorbid Dissociative Disorders (DD) in BPD

Comorbid BPD and DD

- Increased morbidity and poorer functioning than DD without BPD
- **DDNOS** diagnosed in **23.8%-43%** of BPD population (psychiatric outpatients, Sar et al., 2003; Laddis & Dell, 2002; Korzewa et al., 2009)
- **DID** diagnosed in **10%-27%** of BPD population (Conklin & Westen, 2005; Laddis & Dell, 2002; Ross, 2007; Sar et al., 2006; Sar et al., 2003; Korzekwa et al., 2009).
- BPD diagnosed in **30%-70%** of DID population (Boon & Draijer, 1993; Dell, 1998; Ellason et al., 1996; Horevitz & Braun, 1984; Ross et al., 1990; Sar et al., 2003).

Comorbid BPD and DD

+ **Depersonalisation Disorder** diagnosed in **19%** of BPD population (psychiatric outpatients, Korzekwa et al., 2009)
+ **Dissociative Amnesia** diagnosed in **4%-9.6%** of BPD population (psychiatric outpatients, Sar et al., 2003; Korzekwa et al., 2009)
+ **No DD** in **23.8%-30%** of BPD population (psychiatric outpatients, Korzekwa et al., 2009; Laddis & Dell, 2002)

BPD and DID: Same or Different?

- DID as a variant of BPD?

  Outwardly similar patterns and behaviours – structured interview & patterns of comorbidity could not differentiate between them (studies in late 1990s)

  Young (1988) suggested that the defence mechanism of splitting might account for both

- DID as a separate construct?

  Better self-awareness

  Greater capacity at emotion regulation and logical reasoning

  Enhanced stability in interpersonal relationships

  Greater frequency of dissociative experiences

  More severe childhood trauma histories

BPD and DID: notable differences on the MID

- **DID**: High mean scores across all subscales & activity of parts
- **BPD**: flashbacks, identity confusion and memory problems due to depersonalisation, affective instability and pathological absorption/trance
- **But**… those with BPD scoring in the highest range were indistinguishable to those with DID

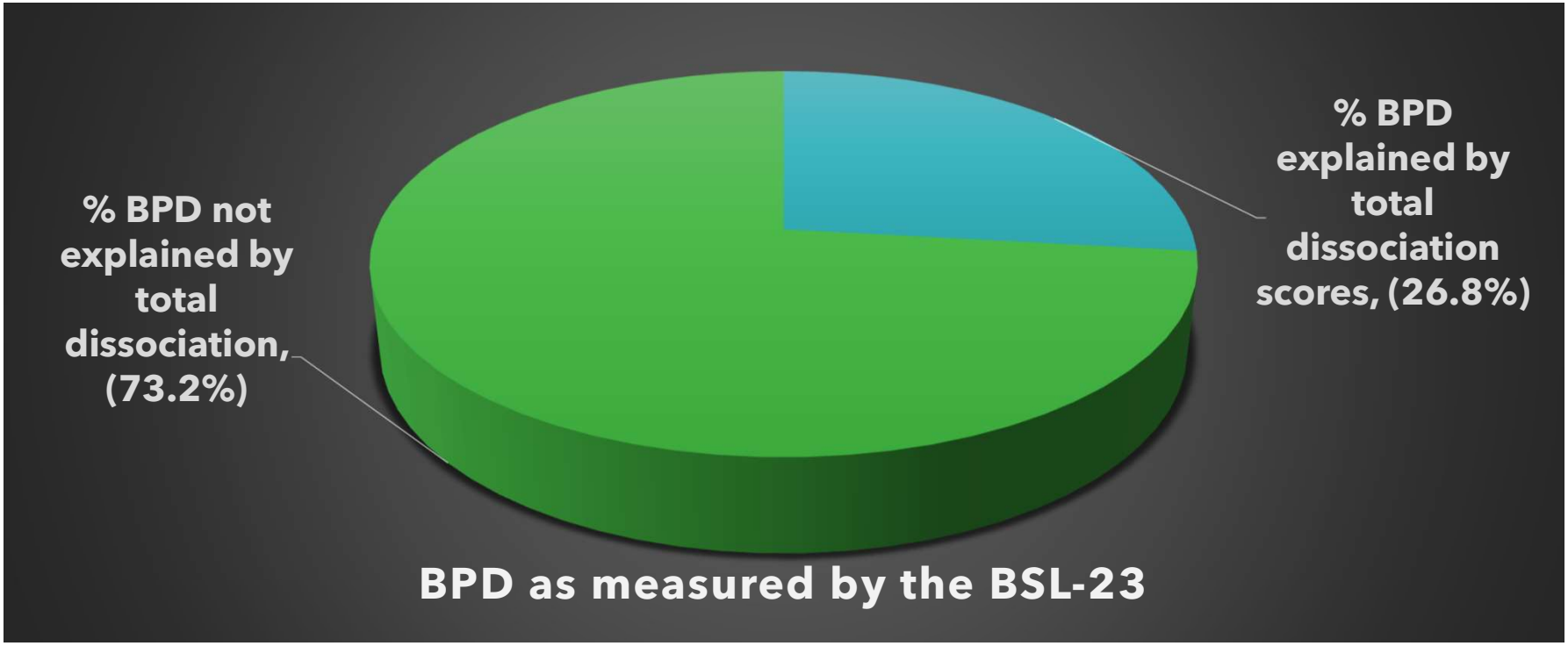
MID = Multidimensional Inventory of Dissociation
Study by Laddis, Dell, and Korzekwa (2016) – 75 DID and 100 BPD

BPD / Dissociation Overlap (our study)

+ Overall dissociation explains **26.8%** of the variance in borderline scores
+ Pathological dissociation alone explains **36.9%** of variance in borderline scores

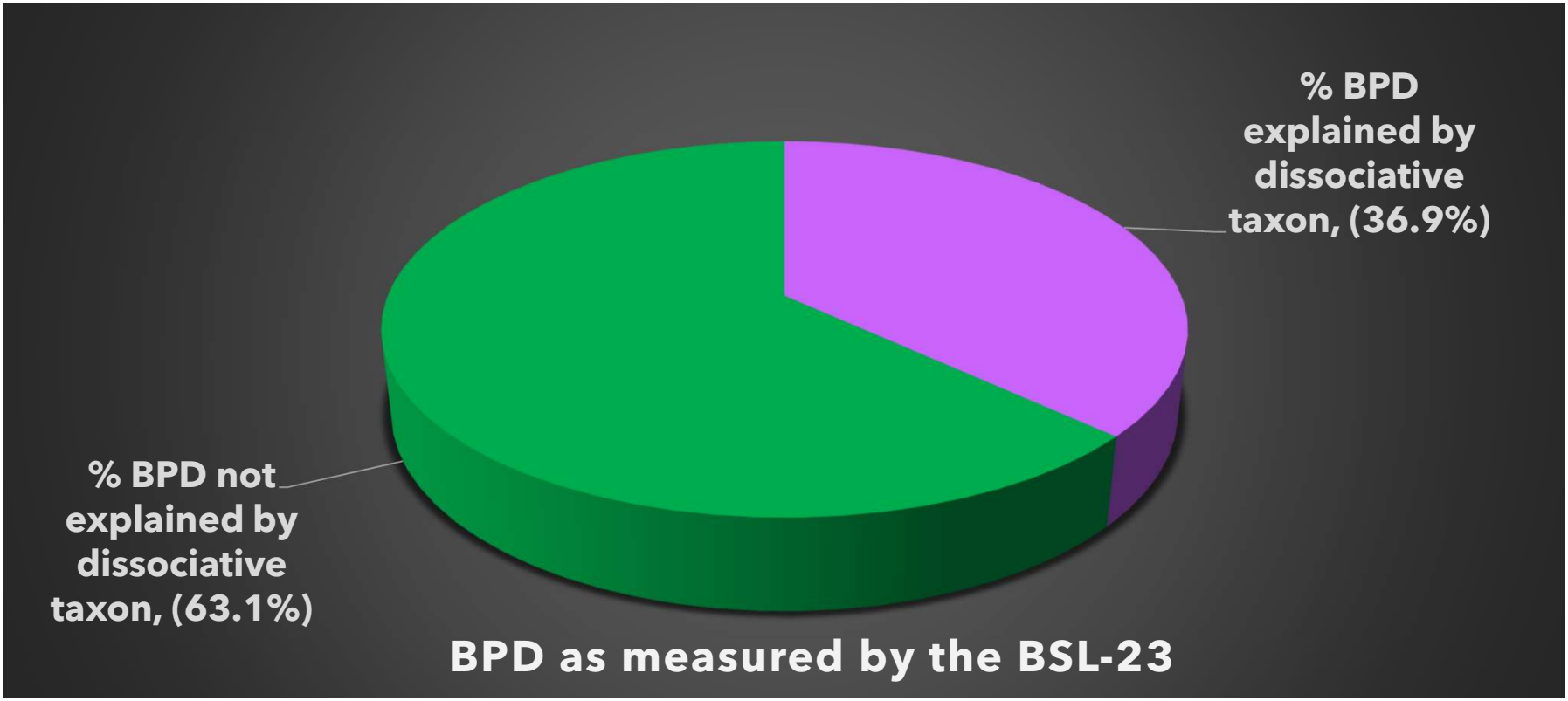
BPD / Dissociation Overlap (our study)

(combination pathological and nonpathological dissociation)



BPD / Dissociation Overlap (our study)

(pathological dissociation only)



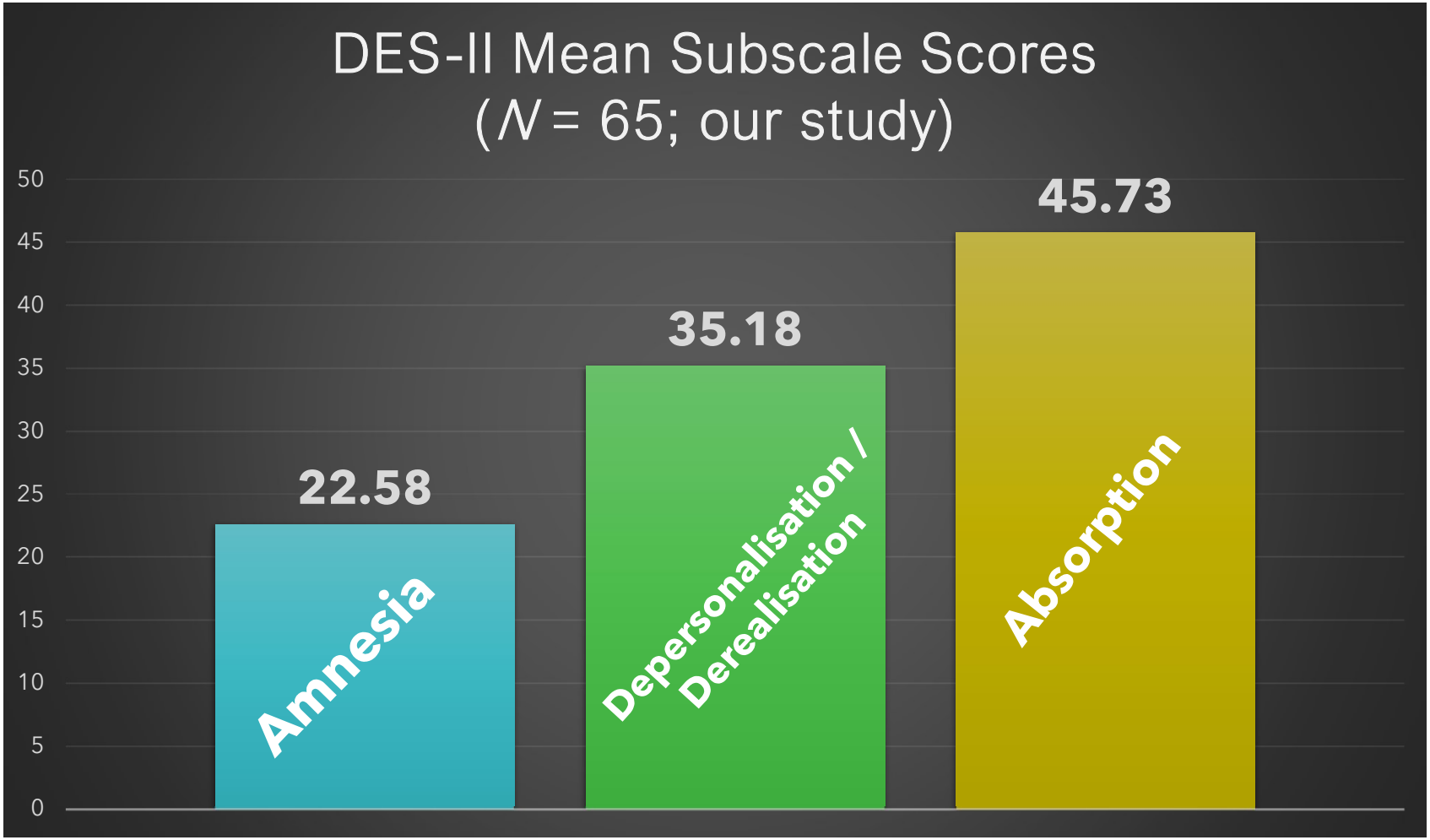
Interpretation of Our Results

+ Underlying common processes between BPD and dissociation
+ As borderline severity increases, so does severity of dissociation

Dissociative Symptoms in BPD

Common Dissociative Symptoms in BPD (Korzekwa, 2009 & Laddis et al., 2002)

+ **Memory problems**: amnesia, memory gaps
+ **Posttraumatic flashbacks**: vivid recall, nightmares, urge to DSH
+ **Intrusive emotions**: rapid unpredictable mood changes
+ **Self-puzzlement**: confused about actions, emotions, identity
+ **Derealisation**: trancing out, “being gone”
+ **Voices/parts**: controlling /criticising / arguing
+ **Thought insertion**: thoughts they can’t stop


DES-II Mean Subscale Scores
(N = 65; our study)
50
45
40
35
30
25
20
15
10
5
0
22.58
35.18
45.73
Amnesia
Depersonalisation / Derealisation
Absorption

Subscale DES-II Scores in Our Study

		M	SD
Full-scale DES-II		36.92	19.34
Amnesia Subscale		22.58	17.76
Derealisation / Depersonalisation Subscale		35.18	26.92
Absorption / Imaginative Involvement Subscale		45.73	20.49

An Aetiological Explanation for the Relatedness of BPD and Dissociation

Attachment and trauma with and without dissociation of the personality (Theory of Structural Dissociation of the Personality)

Attachment Styles

Infant		Adult	
Secure	Secure, explorative, happy	**Autonomous**	Open, honest, coherent discourse, value attachment relationships
Insecure-Avoidant	Not very explorative, emotionally distant	**Dismissing**	Constricted and distant discourse; relationships idealised or devalued
Insecure-Ambivalent	Anxious, insecure, angry	**Preoccupied**	Confused, angry, passive discourse; entangled in relationships
Disorganised	Depressed, angry, completely passive, nonresponsive	**Unresolved**	Global breakdown in discourse around themes of loss or trauma

Disorganised Attachment

The infant must bond with and seek care from a caregiver who is frightening and unpredictable.

This disrupts the organising functions of consciousness, memory, and identity in the infant (see, e.g., Stern, 1985), - the very definition of pathological dissociation (American Psychiatric Association, 1994).

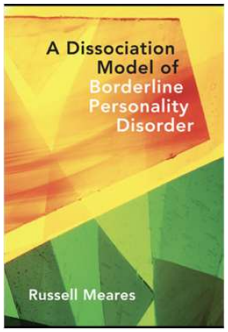
Disorganised attachment can be understood as a very early dissociative process (Main & Morgan, 1996) (Liotti, 2009)

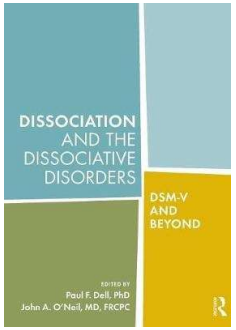
Attachment in BPD

- BPD linked to **insecure** and **unresolved** attachment representations (Bakermans-Kranenburg et al., 2009; Buchheim et al., 2017; Buchheim et al., 2016; Buchheim et al., 2011; Agrawal et al., 2004; Diamond et al., 2014)
- **31.7% unresolved**, 18.3% cannot classify, 30% dismissing, 15% preoccupied (Buchheim et al., 2017; Levy et al., 2006)

Liotti's Vulnerability Theory (1992)

+ Vulnerability is established by a disturbance in **attachment** formation (insecure, disorganised)
+ **IF** suitable subsequent caregiving → integration
+ **BUT IF** continuation or more severe relational disturbance → **disaggregation**[1] = disorganised / unresolved attachment → BPD
+ **AND THEN IF** disaggregation + trauma → **dissociation**[2] → BPD + DD (Meares, 2012; Liotti, 2009)





[1]Disaggregation = failure of mental synthesis (Janet, 1911, 1925)
[2]Dissociation = compartmentalisation - personality divided into more than one person (Janet, 1907)

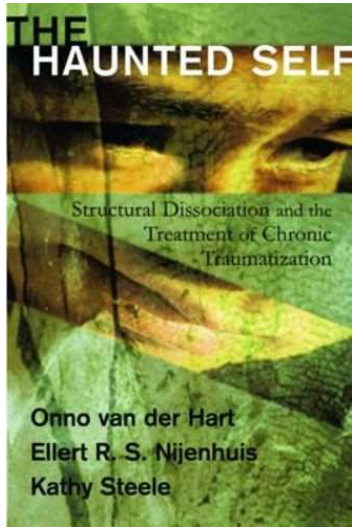
Attachment Style and Trauma

+ The attachment system is **activated** during trauma (strong wish to seek help and comfort) - attachment style constitutes a **template** to respond in a particular way
+ Secure attachment style → my needs for help and comfort will be met and I can actively self-soothe while I wait for support → no disorder
+ Avoidant attachment style → my needs for comfort are illegitimate and will not be met → more painful peritraumatic emotional response and increased risk for trauma-related emotional disorders
+ Ambivalent attachment → my needs for comfort will cause distressing interactions with my caregiver → more painful peritraumatic emotional response and increased risk for trauma-related emotional disorders
+ Disorganised attachment → cannot produce an integrated or organised response → symptoms of dissociation → clinically significant dissociative symptoms

The Theory of Structural Dissociation of the Personality (TSDP)

+ Individuals born as unintegrated personalities
+ Daily life and defensive action systems poised to respond to specific life situations

  Fight, flight, submit, attach, explore etc
+ In a context of **physical and emotional safety and secure attachment with an attuned caregiver** the action systems integrate into a unified whole by about the age of **8 years**
+ Dissociative disorders result if children are confronted with early and severe trauma or frightening and abusive caregivers



Screening, Assessment and Treatment

And a note on clinician training

Tailored treatments which include early identification of dissociation along with strategies to address both BPD and dissociative experiences concurrently, would be both time and cost effective (Korzekwa, Dell, & Pain, 2009).

Screening and Assessment of Dissociation to Inform Treatment Selection

- **Prior** to treating BPD, multistep diagnostic investigation
- Screening (e.g., Dissociative Experiences Scale – DES-II)
- Structured interview (e.g., Structured Clinical Interview for DSM Dissociative Disorders – SCID-D) or Multidimensional Inventory of Dissociation (MID) https://www.mid-assessment.com/
- Additional questions about trauma history, attachment and parenting styles

Measures to Assess Dissociation

+ Measures

  Dissociative Experiences Scale (DES-II)

  Dissociative Disorders Interview Schedule (DDIS)

  Structured Clinical Interview for DSM Dissociative Disorders (gold standard) (SCID-DD)

  Somatoform Dissociation Questionnaire (SDQ)

Screening and Assessment of Dissociation to Inform Treatment Selection

+ Comorbid BPD and DD require modified treatment protocol including additional safety planning and stabilisation, e.g., parts work (egostate therapy, internal family systems)
+ Comorbid BPD and DID require phased treatment:

  Stabilisation (psychoeducation, skills building, social skills training, education about trauma, containment of trauma, grounding, safety planning)

  Trauma processing

  Integration and rehabilitation

Treatment Recommendations

Dissociation Score*	Dissociative Symptoms	Attachment / Trauma	Treatment
High	Compartmentalisation and amnesia	Disorganised attachment and severe / chronic abuse	Parts work, integration of functions (Forgash & Copeley, 2012; Steele et al., 2017; Chefetz, 2015; also see Richard Kluft and Colin Ross)
Moderate	Depersonalisation and derealisation	Insecure or disorganised attachment and at least some abuse history	Emotion recognition, tolerance and regulation, grounding, arousal modulation (Linehan, 2014; Steele et al., 2017)
Low	Absorption / imaginative involvement	Insecure attachment and minimal or no abuse history	Mindfulness, present focus, attention training (Linehan, 2014; Steele et al., 2017; Soffer-Dudek et al., 2015; Callinan et al., 2015)

*Structured Clinical Interview for DSM-IV Dissociative Disorders – Revised (SCID-D), the Multidimensional Inventory of Dissociation (MID), the Dissociative Experiences Scale (DES-II), and the Somatoform Dissociation Questionnaire (SDQ)

Clinician Training

- Average duration of dissociative disorders going undetected while the individual receives treatment is 6.8 years
- Average number of diagnoses individuals receive while their true diagnosis goes undetected is three to four (Putnam, Guroff, Silberman, Barban, & Post, 1986)

Clinician Training

+ Training in understanding, identifying and managing dissociation is required – particularly for clinicians treating BPD (remember 64% of a DBT outpatient sample reported pathological dissociation)
+ The theory of structural dissociation comprehensively explains dissociation across all levels of severity and is supported by neurobiological evidence

What I would like you to take away

(1) Dissociation is **common and severe** in BPD
(2) Most clinicians do not have a good understanding of this, or how to identify and manage it
(3) This is an important problem because BPD places a huge burden on society
(4) …adding dissociation increases this burden
(5) One way to understand dissociation in BPD is through the lens of **attachment** and **trauma**
(6) Formulating BPD + dissociation in this manner can inform appropriate screening, assessment & treatment

Discussion Questions

1. Do you assess for dissociation in BPD?
2. What types of dissociative symptoms have you noticed most commonly accompany BPD?
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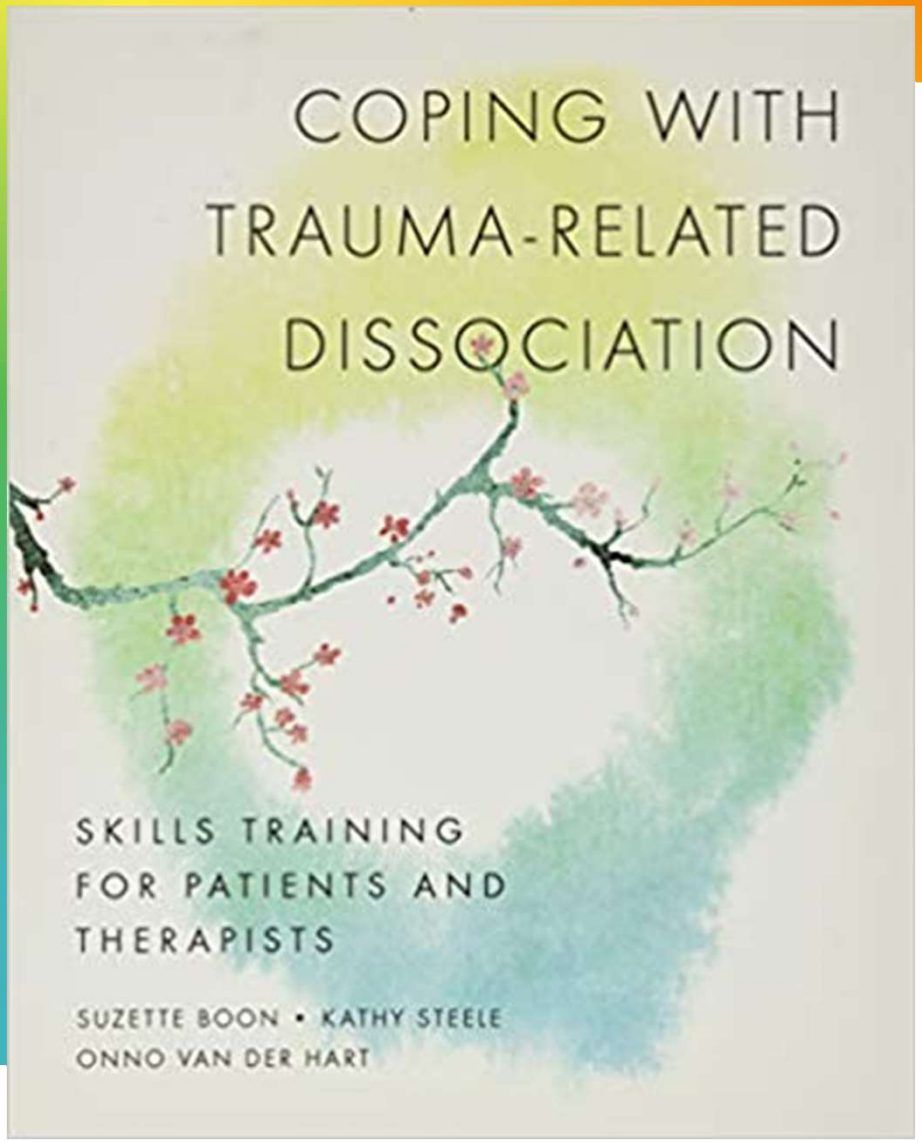
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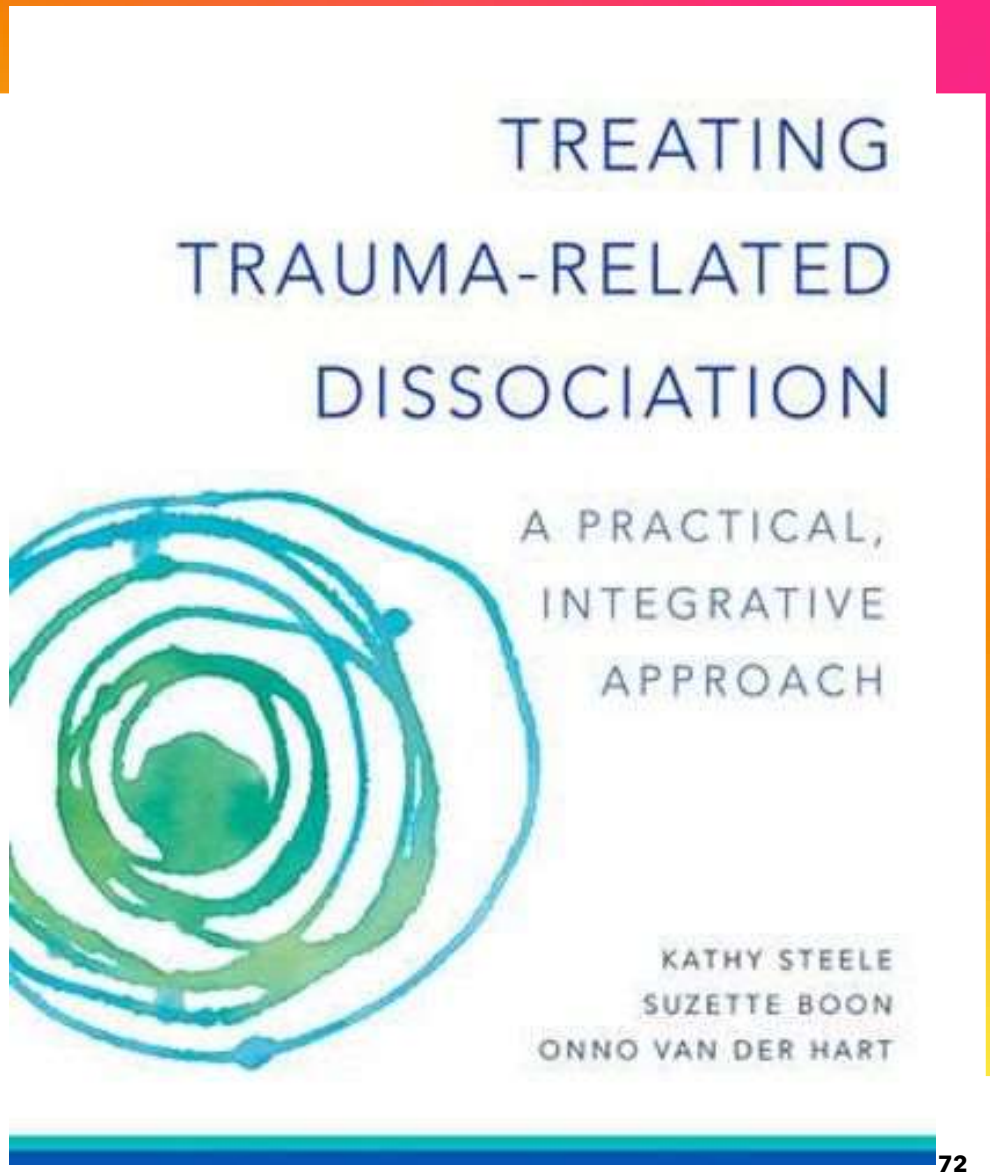
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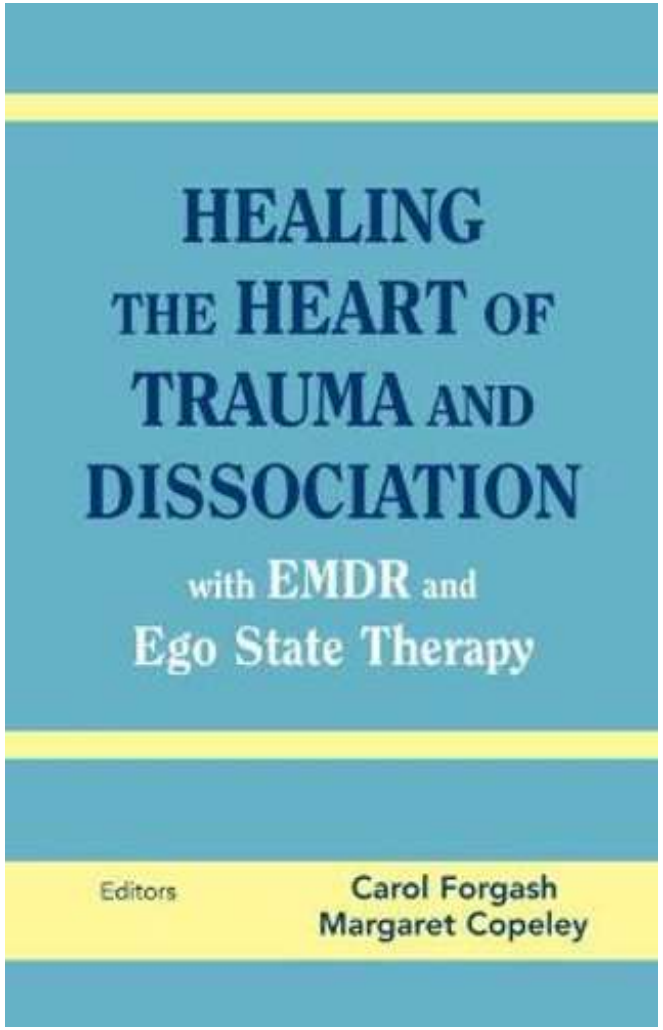
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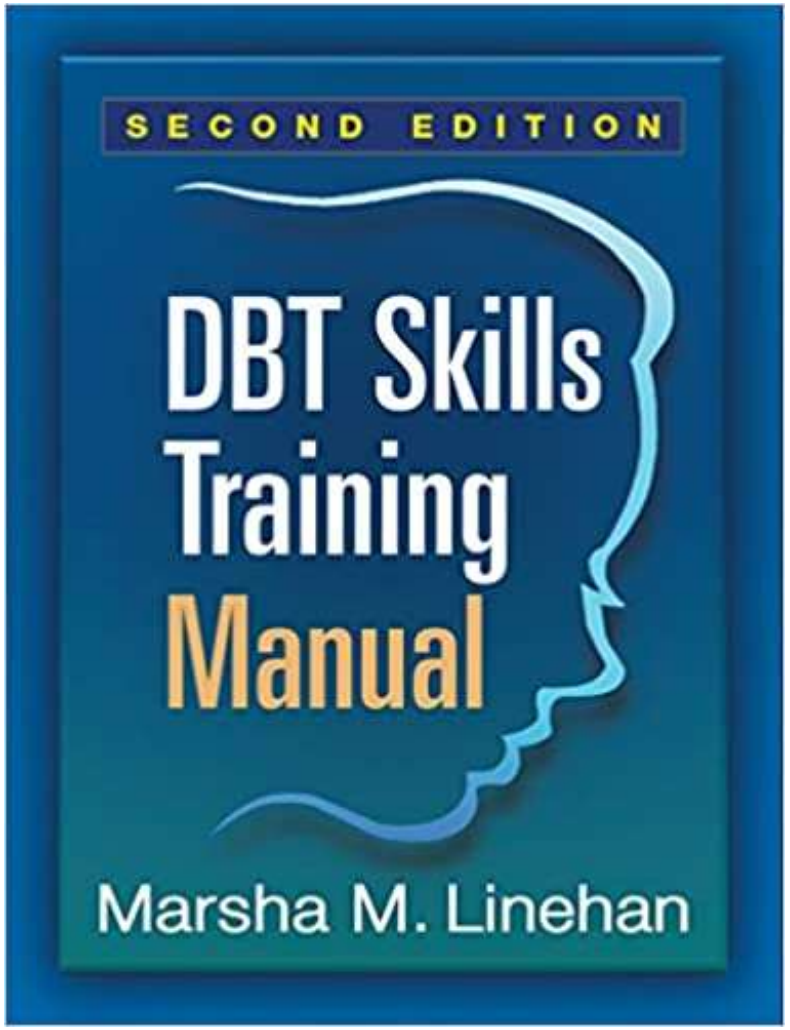
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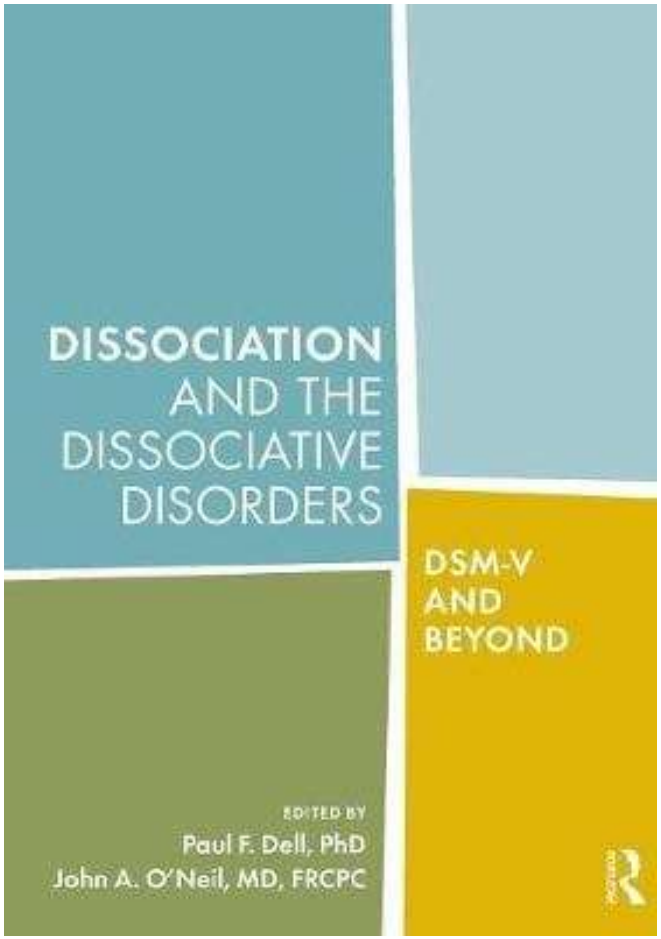
DISSOCIATION
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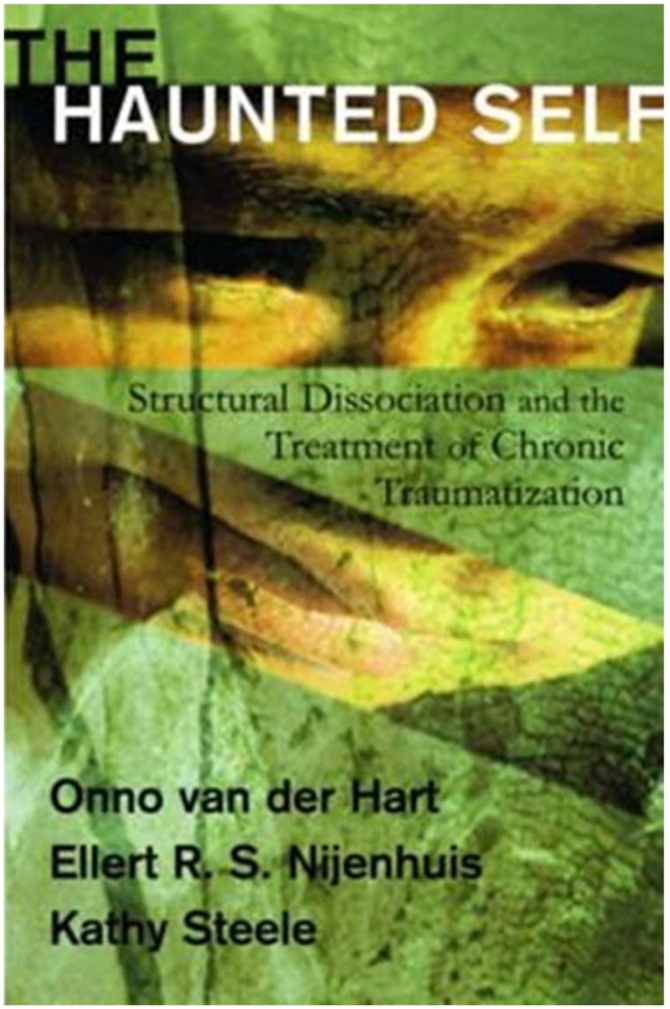
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Structural Dissociation and the
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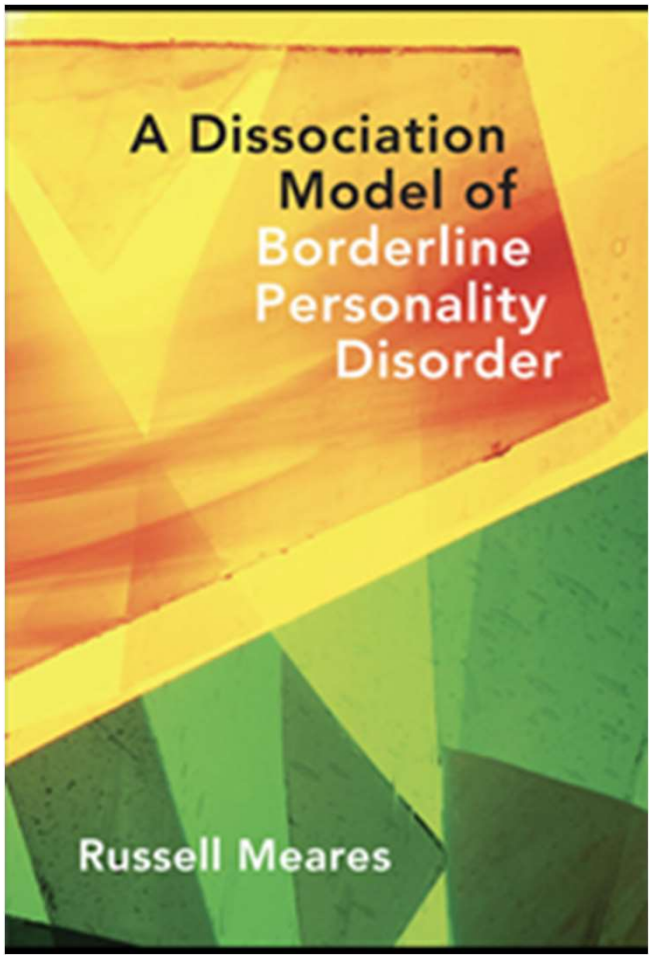
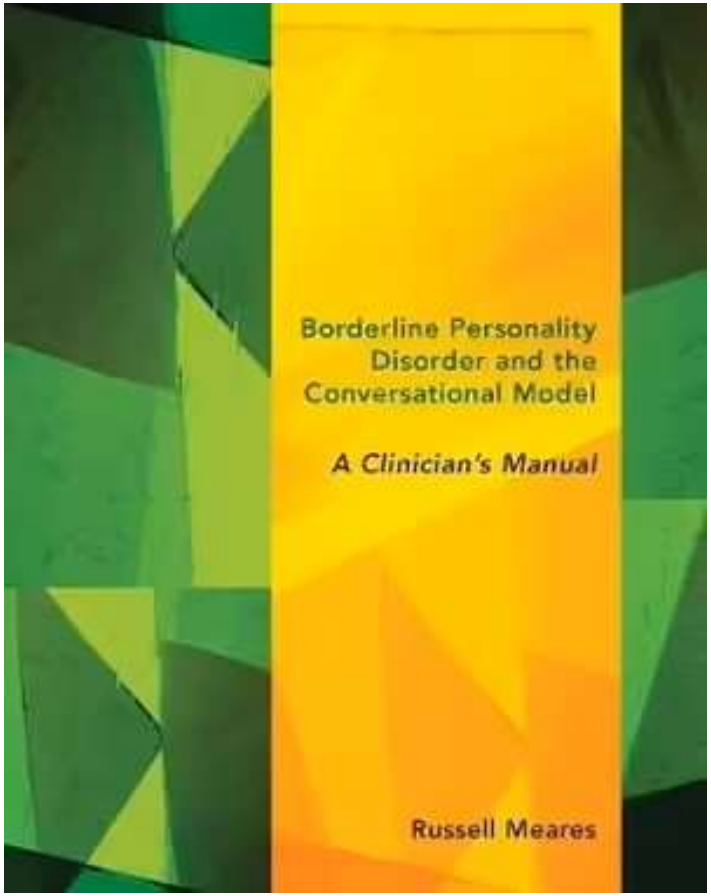

A Dissociation Model of Borderline Personality Disorder
Russell Meares


Borderline Personality Disorder and the Conversational Model
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Thank you ☺