Dialectical Behaviour Therapy Treatment of Borderline Personality Disorder Symptomology: Managing Powerful Emotions
by
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Dedication

I wish to dedicate this thesis to my family; I have always been able to count on them for support and friendship. Without them I would not have been able to make it this far in my educational career.
Abstract
Borderline personality disorder (BPD) is a pervasive and complex mental illness that has serious personal and social consequences (i.e. unemployment and small support group). Empirically supported treatment for BPD has been developed within the last decade and a half. Individuals (n = 53) that participated in a 14-week modified DBT group treatment plan were assessed for emotional regulation improvement using the DERS and SAQ. The results indicate that participant’s scores decreased on the DERS from pre- (M = 119.69, SD = 25.17) to post testing (M = 96.15, SD = 8.49; t(52) = 6.77, p < .001, d = .96 (two-tailed) and increased on the SAQ from pre-test (M = 26.42, SD = 8.49) to post-testing (M = 31.50, SD = 7.76, t(41) = -2.61, p < .001, d = 0.62 (two-tailed). The current thesis contributes to the growing literature supporting the use of DBT treatment for individuals with BPD or emotional dysregulation. Recommendations for future research were to include a control trial and larger sample sizes. Strengths, limitations, multilevel challenges to service implementation, and recommendations for future research are discussed.
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Chapter I: Introduction

Personality disorders (PDs) are among the more complex and challenging mental illnesses to treat given that they are maladaptive personality styles derived from predisposing temperaments, stressful environments, and poor parenting styles. Interestingly all humans have some or all features from the three clusters of personality disorders, however, these features become a problem when maladaptive styles become enduring, stable, and static. Personality disorders are defined by adverse ways of thinking and feeling about oneself and others that significantly affect how individuals function on a daily basis (American Psychiatric Association, 2013).

A particularly challenging personality disorder to treat successfully is borderline personality disorder (BPD; Cellucci, 2016; Linehan, 1993; McMain, 2015; Loveless, Whited, & Rhodes, 2016). The Diagnostic and Statistical Manual of mental disorders 4th Edition (DSM-IV; American Psychiatric Association, 2000) and DSM-5 (American Psychiatric Association, 2013) identified the diagnostic criteria for BPD as: fear of abandonment, poor interpersonal relationships, unclear self-image or identity, impulsive behaviour, self injurious behaviour (cutting, eating disorders, suicide attempts, parasuicide etc.), emotion dysregulation, feelings of emptiness, difficulties controlling intense emotions, and transient absence of feelings of connectedness (American Psychiatric Association, 2012). Treatment of BPD has proven to be a difficult task due to the fact that BPD is most often comorbid and presents with other personality disorders, mood disorders, anxiety and substance use disorders (Levy et al., 2006; Brown, 2016; Have et al., 2016). Have et al. (2016) state that prevalence rates of BPD range from 0.5% to 1.4% of the total population in American studies; some studies suggest higher rates of 2.7% and 5.9% of the total population. The increase in BPD prevalence has resulted in strains on mental health care systems (Bagge, Stepp, & Trull, 2005; Dixon-Gordon, Peter, Fertuck, & Yen, 2016; McMain, 2015).

Affective disorders, including BPD, bipolar disorder (BP), and depression, are often characterized by the inability to regulate emotions. Emotion regulation is learned at a young age and carried on throughout adolescence and adulthood. The ability to manage or regulate emotions is a key skill as it allows for the development of functional relationships with others and with the self. The term emotion regulation is used commonly in research regarding individuals with BPD and BD (Frías, Baltasar, & Birmaher, 2016; Linehan, 1993) however the term itself is one that encompasses complex structures that are interrelated and constantly shifting (Linehan, 1993). To regulate one’s emotions is to first, recognize that an emotion is taking place within the body and the mind, this includes being able to identify the emotions (e.g. sadness, anger, happiness) and the ability to understand why that emotion is happening given the context of the situation (Bateman & Fonagy, 2015). Second, emotion regulation includes the strategies that are used to cope with the emotions in a healthy and constructive way rather than a destructive way, thus leading to a type of emotional stability. The consequence resulting from an inability to regulate emotions is emotion dysregulation. A key feature of BPD is emotion dysregulation, that is, impaired emotional awareness that leads to rapid shifts between moods, low return to emotional baseline, poor interpersonal skills, and poor emotional coping strategies (Bales, Parker, & McClure, 2016). Emotional regulation tends to be a daily, if not hourly, challenge for individuals with BPD. Considering the extent to which individuals with BPD experience emotion dysregulation the use of a DBT skills based group that focuses on distress tolerance and emotion regulation is warranted and necessary.
Dialectical Behaviour Therapy (DBT) is a skills building based cognitive behaviour therapy that was developed by Marsha Linehan to treat individuals diagnosed with BPD. The treatment involves four modules: distress tolerance, emotion regulation, interpersonal effectiveness, and mindfulness. The main goals of DBT are to teach healthy coping skills to use in distressing situations, learn how to control emotional reactions, engage in effective communication, and be aware of the present moment (Linehan, 1993). Individuals with emotion regulation difficulties, specifically individuals with BPD, lack the ability to identify, monitor, and modify intense emotional reactions. Linehan (1993) presents a biosocial theory that states that BPD occurs as a result of the complex interplay of the child’s biological emotional vulnerability and environmental responses that invalidate the child’s negative affect. This invalidation of negative affect results in the child’s inability to identify or express emotions in an appropriate way. Inabilities such as these create difficulties in interpersonal interactions and the development of healthy coping techniques.

The purpose of the thesis was to investigate the feasibility of a group treatment approach that focused on implementing DBT skills to treat symptoms of BPD. The group treatment is labeled Managing Powerful Emotions (MPE). MPE focuses on the distress tolerance and emotion regulation modules of DBT. The first objective of the group is to provide clients with distress tolerance strategies that can be implemented in a wide variety of distressing situations. The second objective is to help the clients through emotional processing, and the third is giving the participants a brief introduction to the last two DBT modules, interpersonal effectiveness and mindfulness.

The information that follows includes a literature review, a method section, a results section, and a conclusion and discussions section. The literature review evaluates and summarizes past experiments, studies, theoretical articles, and literature reviews. The review also compares and contrasts treatment approaches, such as stand-alone DBT treatments and DBT in combination with other approaches. Effective techniques were discussed as well as common issues that arose while treating individuals with BPD. The method section summarizes the methodology of the thesis project. It includes a description of the participants, selection procedures, the format of the study design, a description of the measurement scales, a description of how the archival data was analyzed, and overview of the program procedures. The results section focuses on reporting the findings from a repeated-measures analysis of variance (ANOVA) conducted on pre- and post-group questionnaires completed by participants. A visual analysis is also included in this section. The conclusion and discussion section includes interpretation of the archival data that was used in the analysis. This section also discusses the strengths and limitations of the project, impact future research and practice and recommendations for future research.

Symptoms of BPD can be treated effectively using a cognitive behavioural therapy approach, DBT (Linehan, 1993). In order to test this statement it is hypothesized that participation in a 14-week group labeled Managing Powerful Emotions (MPE), a DBT skills based group that focuses on distress tolerance and emotion regulation, will be effective in decreasing emotional dysregulation and increasing a sense of control over emotions.
Chapter II: Literature Review

BPD is multi-faceted and requires an intervention that targets emotional dysregulation, distress tolerance, interpersonal deficits, and the client’s tendency to dissociate or split from the self. BPD symptoms can be treated successfully using elements of psychodynamic therapy and DBT. Rivera and Darke (2012) state that a range of modalities and interventions are effective in treating individuals that deal with complex, enduring, and multi-level symptoms, such as those associated with BPD. Despite this, treating BPD using a stand-alone DBT skills based approach has shown beneficial results (Clarkin et al., 2007; Linehan, Heard, & Armstrong, 1993; Moore et al., 2016, O’Connell & Dowling, 2014); the literature reviewed below evaluates and summarizes the effectiveness of DBT treatment of BPD as well as a range of other disorders that present similar symptomology as BPD.

O’Connell and Dowling (2014) suggest that DBT is now the treatment of choice for BPD, as it is a skill-focused treatment that is effective in empowering BPD clients by providing them with constructive coping skills. Koons et al. (2001) found that compared to a treatment as usual (TAU) group, females aged 21 to 26-years-old with BPD that engaged in a DBT based group reported significant decreases in suicidal ideation, self-injurious behaviour, and anger experienced but not expressed. Barnicot, Gonzalez, McCabe, and Priebe (2016) discovered that individuals who used DBT skills at any point throughout therapy were less likely to drop out and DBT skill use was associated with higher self-efficacy and a reduction in self-harm.

In a study conducted by Panepinto, Uschold, Olandese, and Linn (2015) 110 students aged 18 to 48-years-old (85 females and 25 males) were engaged in a DBT program. The study was run through the college counseling center, 64 students completed group skills sessions and both pre- and post-assessments. The program included individuals with a BPD diagnosis (n = 8%) as well as individuals presenting with features of OCD, interpersonal sensitivity, depression, anxiety, psychoticism, somatization, and attention-deficit/hyperactivity disorder (Panepinto, Uschold, Olandese, & Linn, 2015). The program focused on two of the DBT modules: emotional regulation and interpersonal effectiveness. Participants engaged in weekly group skills training session, biweekly individual sessions, and skills coaching (via telephone or in person). Overall, the study found that the targeted areas of emotional regulation and interpersonal effectiveness increased significantly in individuals with BPD and the disorders stated above (Panepinto et al., 2015).

The literature discussed above ranges across various populations, ages, settings, and diagnoses. Koons et al. (2001) only included individuals with a diagnosis of BPD in the research study, while Panepinto et al. (2016) included individuals with BPD and other disorders in the study. Both studies resulted in decreases in emotional dysregulation and an increase in interpersonal stability (Koons et al., 2001; Panepinto et al., 2016). Interestingly, even though neither Koons et al. (2001) nor Panepinto et al. (2016) used traditional DBT procedures (phone coaching, group therapy, individual psychotherapy, and team consultation meetings), the treatments elicited beneficial changes or the participants. Koons et al. (2001) did not include skills coaching via telephone, a treatment aspect of Linehan’s original procedure for DBT, as a part of the treatment procedure whereas Panepinto et al. (2016) did. Koons et al. (2001) may have more meaningful findings due to the fact that the researchers included a TAU group in order to compare the findings from the DBT group. Although only 8% of participants in Panepinto et al. (2016) study had a diagnosis of BPD, individuals with interpersonal sensitivity, depression, and ADHD experience difficulties in emotion regulation and interpersonal effectiveness (Ehring, Tuschen-Caffier, Schnülle, Fischer, & Gross, 2010; Joormann & Gotlib,
Both studies demonstrate that a DBT skills based treatment can be useful when the target is to improve coping skills in the areas of emotion regulation and interpersonal interactions.

Individuals within the correctional population experience similar symptomology to BPD clients (Moore et al., 2016; Trupin, Stewart, Beach, & Boesky, 2002; Zlotnick, 1999). Such as, poor interpersonal skills, affective instability, intense anger, and feelings of emptiness. In the study by Moore et al. (2016) DBT skills groups were implemented at a correctional agency. The study adapted DBT elements to deliver inmates (N = 16) a skills building group targeted towards employment skills (Moore, et al., 2016). The length of the DBT treatment was shortened from the common 24-week treatment to an 8-week treatment (Moore et al., 2016). The results showed that from pre- to post-testing inmates appeared to externalize blame and take their anger out on others less often; considering time restraints the results demonstrated by Moore et al. (2016) are beneficial to future researchers and support the use of DBT in correctional agencies. The study was able to demonstrate positive effects of DBT with individuals who experience symptoms that commonly display symptomology similar to BPD.

A study conducted by Pistorello, Fruzzetti, MacLane, Gallop, and Iverson (2012) sought to examine the effectiveness of DBT for suicidal college students aged 18 to 29-years-old. Three out of the 63 students met the BPD diagnostic criteria while the other participants were experiencing BPD symptomology (Pistorello, Fruzzetti, MacLane, Gallop, & Iverson, 2012). Students were assigned to DBT conditions (n = 31) or TAU group (n = 32) (Pistorello et al., 2012). Both of the treatment conditions lasted 7-12 months, both conditions included individual and group components. Those that were in the DBT group underwent skills training in mindfulness, emotion regulation, distress tolerance, and interpersonal effectiveness. The DBT treatment closely resembled the standard set by Linehan (1993), biweekly individual sessions, weekly group sessions, weekly individual psychotherapy, and skills coaching if needed. The duration of some of the distress tolerance modules were shortened for the current study. The results indicated that clients in DBT compared to the control condition showed significantly greater reductions in BPD criteria (Pistorello et al., 2012).

In comparison Moore et al. (2016) and Pistorello et al. 2012 both used modified DBT groups to decrease BPD criteria (poor affective regulation, interpersonal interactions, and coping skills). However, Moore et al. (2016) did not have individuals with a diagnosis of BPD in their study but instead examined a group of individuals that present similar features to those of BPD (Steadman, Osher, Robbins, Case, & Samuels, 2009). Both studies had to shorten treatment due to time restraints. It was unspecified in the Moore et al. (2016) study which sex (male or female) were included in the study. Pistorello et al. (2012) examined the effectiveness of DBT among the student population while Moore et al. (2016) examined inmates in a correctional facility. In contrast to Moore et al. (2016) Pistorello et al. (2012) included a control group in order to strengthen the validity of the results. Regardless of the participant’s diagnoses, sex, age, and location at the time of the study both Moore et al. (2016) and Pistorello et al. (2012) were able to demonstrate DBT skills can be an effective treatment to decrease emotional dysregulation (i.e. emotional outbursts) and destructive behaviours (i.e. suicidal ideation).

A particularly interesting study conducted by Martin, Roos, Zalewski, and Cummins (2016) sought to implement DBT skills with mothers who experienced poor emotion regulation as a means to decrease emotion dysregulation symptoms and improve parenting behaviours.

Primary caregivers with poor emotion regulation have been linked to greater likelihood of child maltreatment (Skowron, Kozlowski, & Pincus, 2010), use of harsh disciplines strategies, and
greater maternal rejection or hostility (as cited in Saritas, Grusec, & Gençös, 2010). The participants attended weekly group sessions, individual sessions, and phone-calls as needed for 22-weeks. All four modules of DBT were covered over the treatment duration and two mothers engaged in pre- and post-testing. Both mothers reported having difficulties in emotion regulation (i.e. managing anger and feelings of depression and anxiety), interpersonal relationships, and met diagnostic criteria for substance dependence (Martin, Roos, Zalewski, & Cummins, 2016). The use of DBT skills was tracked using a DBT diary card, the participants were asked to check off as many DBT skills that they practiced each day of the week, and an exit interview. The results indicate that both mothers reported using DBT skills helped them during interpersonal interactions with their children (e.g. they were both more able to identify what their child was feeling at a given point in time), stress-related to parenting decreased, level of psychological control increased, and DBT skills were effective in regulating their own emotions (Martin et al., 2016).

Wilks, Valenstein-Mah, Tran, King, Lungu, and Linehan (2016) were interested in the outcome of a DBT skills building group treatment that was implemented among family members who have siblings with behavioural disorders. The study included 20 participants and focused on teaching family members DBT skills (emotion regulation, interpersonal skills, distress tolerance, and mindfulness) as a means to cope with the emotional and physical stress that can result due to caring for a mentally ill individual (Wilks et al., 2016). The treatment lasted 6-months and met weekly for one and a half hours. Interestingly, the DBT treatment appeared to be a feasible approach when the target is to increase emotion regulation and distress tolerance in individuals who have no behavioural disorders (Wilks et al., 2016). Wilks et al. (2016) was able to demonstrate that DBT skills can be effectively implemented among mentally healthy individuals and produce increases in emotional awareness, attention, and communication effectiveness.

Goldstein et al. (2015) sought to examine the differences between a TAU and a DBT group for individuals diagnosed with BD. Individuals with BD experience similar symptoms to those diagnosed with BPD, the commonality of symptoms has led to multiple cases of misdiagnoses (Paris, 2009; Ruggero, Zimmerman, Chelminski, & Young, 2010). Adolescents aged 12 to 18-years-old (n = 20) diagnosed with BD were included in the study. Individuals in the DBT group engaged in 36 sessions (individual and family skills training) over the course of one-year. The TAU group was a type of psychotherapy approach consisting of psychoeducation, supportive and cognitive behavioural techniques (Goldstein et al., 2015). At the one-year follow-up the researchers found that compared to the TAU group, the DBT group attended more sessions overall, displayed less severe depressive symptoms, showed reductions in suicidal ideation, and demonstrated increases in emotional dysregulation from pre- to post-testing (Goldstein et al., 2015).

The comorbidity of BPD and posttraumatic stress disorder (PTSD) has been growing and has resulted in the exploration of effective treatments for such a pairing of complex and severe disorders. Granato, Wilks, Miga, Korslund, and Linehan (2015) conducted a case study to evaluate an integrated treatment approach for an individual with BPD and PTSD. The client underwent a DBT and prolonged exposure (PE) therapy treatment. The treatment lasted for 10-months and included 14 sessions of traditional DBT (weekly psychotherapy, group skills training, phone coaching, and weekly therapist consultation meetings) followed by 27 sessions of DBT PE protocol. The client completed two types of measurement throughout the treatment, a DBT diary card and the PTSD checklist (Granato, Wilks, Miga, Korslund, and Linehan, 2015).
Interestingly, the results demonstrate that the client showed a reduction in suicidal ideation and self-harming behavior from pre- to post-testing (Granato et al., 2015).

In contrast Goldstein et al. (2015) was able to incorporate a TAU group as well as a DBT treatment group, allowing the researchers to compare the effect sizes between the two treatments. Granato et al. (2015) conducted a case study, which only followed the treatment of one individual whereas Goldstein et al. (2015) included 20 participants in the study. Additionally, Goldstein et al. (2015) targeted the adolescent population while Granato et al. (2015) followed a 31-year-old female. The two studies also differed in terms of which populations were examined; Goldstein et al. (2015) included participants with BD and Granato et al. (2015) included a female with a comorbid expression of BPD and PTSD. BD and BPD have been known to be difficult to distinguish between at times in terms of diagnostic criteria (Bayes, Parker, McClure, 2016; Goldstein et al., 2015). Individuals with BD and BPD relate in terms of emotional dysregulation (impairing awareness of emotions, mood shifts, and emotional stability); the main difference between the two is the degree to which the emotion dysregulation affects the individual (Bayes, Parker, & McClure, 2014). Regardless of severity of emotion dysregulation or presenting disorder both Goldstein et al. (2015) and Granato et al. (2015) implemented DBT based treatments. Goldstein et al. (2015) used a modified DBT treatment approach whereas Granato et al. (2015) implemented a traditional DBT approach. Despite the differences between the two studies both were able to demonstrate decreased suicidal ideation and an improvement in emotion regulation.

Panos, Jackson, Hasan, and Panos (2014) conducted a meta-analysis of five randomized controlled trials that investigated the feasibly of DBT in reducing suicide, parasuicide, treatment attrition, and symptoms of depression in individuals with BPD. The results indicate that DBT was only slightly more effective than TAU in reducing attrition during treatment, however it was significantly more effective when the aim is to stabilize and control self-destructive behaviours (parasuicide and suicide attempts). (Panos, Jackson, Hasan, & Panos, 2014). Similarly, Kliem, Kröger, and Kosfelder (2010) completed a systematic review of 26 peer reviewed journal articles that focused on the efficacy and effectiveness of DBT. The researchers discovered moderate effect sizes for the use of DBT with BPD (Kliem, Kröger, & Kosfelder, 2010). However, when DBT was compared to TAU groups, the researchers found no significant differences between the treatment results, this varied depending on the study and the symptomology examined (Kliem et al., 2010).

Clarkin, Levy, Lenzenweger, and Kernberg (2007) evaluated the effectiveness of three different yearlong treatments for BPD, DBT, transference-focused psychotherapy (TFP), and a dynamic supportive treatment. Individuals in the DBT treatment group went through the steps associated with DBT: mindfulness, distress tolerance, interpersonal effectiveness, and emotion regulation. The TFP group underwent therapy sessions where they focused on recognizing each part of their own “self” and work away from the splitting of the self that occurs due to characteristics of BPD (Clarkin et al., 2007). The dynamic supportive treatment was not fully explained in the context of the article however the authors noticed significant improvements from all three of the treatments.

Gregory and Sachdeva (2016) conducted a study that examined three different treatment groups, DBT group, Dynamic Deconstructive Psychotherapy group (DDP), and TAU. The DBT group was a skills building based group and delivered traditional DBT material. DDP is a relatively new form of psychotherapy that encompasses translational neuroscience, object relations theory, and deconstructive philosophy (Gregory & Sachdeva, 2016). The primary
measurement scale used was the Borderline Evaluation of Severity over Time Scale (BEST), a 15-item, self-report questionnaire that is designed to assess the changes in the severity of BPD. The BEST includes three subscales, thoughts and feelings (mood reactivity, feelings of emptiness, and suicidal thinking), negative behaviours (self-injury), and positive behaviours (follow through with treatment plans); higher scores on the subscales indicate greater symptomology severity (Gregory & Sachdeva, 2016). The treatments lasted 12-months and included a total of 68 participants. The results showed clients in the DBT and DDP groups improved significantly on the BEST over the 12-month treatment, whereas the TAU group did not improve over the 12-months (Gregory & Sachdeva, 2016). Interestingly, the level of attrition in the DDP group was significantly less than that of the DBT group and overall effect sizes were higher in the DDP group.

Clarkin et al. (2007) and Gregory and Sachdeva (2016) conducted studies that compared the effectiveness of three different groups, DBT, transference focused psychotherapy (TFP), and a dynamic supportive treatment. Clarkin et al. (2007) evaluated the three treatment groups to determine effective approaches for the treatment of BPD. Researches found all three groups were effective for treating BPD. Gregory and Sachdeva (2016) evaluated a DBT skills based group, dynamic deconstructive psychotherapy group (DDP), and a TAU. The Clarkin et al. (2007) study lasted 11-months compared to the 12-month Gregory and Sachdeva (2016) treatment, such a small difference in treatment length cannot be attributed to variance in treatment results. The Gregory and Sachdeva (2016) study may be more influential due to the use of a dynamic supportive group, which was used a control group for the other two treatments. The results showed that in comparison to the supportive treatment group, both the DBT and DDP group were more effective treatments for individuals with BPD (Gregory & Sachdeva, 2016). Compared to the DBT group, individuals that participated in the DDP group showed slightly lower attrition levels (Gregory & Sachdeva, 2016). Regardless, both treatments showed moderate to large effect sizes.

BPD is a serious and complex mental health illness. It is characterized by poor affective regulation and interpersonal relationships, impulsivity, feelings of emptiness, and identity disturbances (American Psychiatric Association, 2013). Until recently BPD has been viewed as untreatable and due to more comprehensive diagnostic criteria BPD diagnoses have increased, resulting in a strain in the health care system as treatments and practitioners are needed (Bagge, Stepp, & Trull, 2005; Dixon-Gordon, Peter, Fertuck, & Yen, 2016; McMain, 2015). Loveless (2016) and Whited, Rhodes, and Cellucci (2016) suggest an integrated treatment protocol is most effective for treatment of BPD due to the complexity of the disorder however, a larger amount of research supports the use of a stand-alone DBT treatment for individuals experiencing BPD and BPD symptomology (Goldstein et al. 2015; Linehan, 1993; O’Connell & Dowling, 2014; Panepinto et al., 2015; Pistorello et al., 2012). The literature discussed above provides evidence that supports the use of DBT based skills groups for the treatment of BPD. Multiple peer reviewed studies demonstrate and support the use of a DBT skills group for the treatment of individuals diagnosed with BPD (Barnicot et al., 2016; Granato et al., 2015; Kliem et al., 2010; Koons et al., 2001; Panepinto et al., 2015; Pistorello et al., 2012) as well as individuals with other pathologies such as OCD, BD, anxiety disorder, depressive disorder, PDs (Goldstein et al., 2015; Martin et al., 2016; Moore et al., 2016; Panepinto et al., 2015; Pistorello et al., 2012). The DBT treatments yielded significantly higher results in terms of emotional regulation, overall reduction in symptomology (suicidal ideation, parasuicide behaviour, self-harm, and depression), and interpersonal stability compared to TAU groups (Panepinto et al., 2015; Pistorello et al.,
2012). Similarly, Panos et al. (2014) conducted a meta-analysis of DBT based treatments and found them to be significantly more effective in stabilizing and controlling self-harming behaviours as well as emotion regulation. Therefore, a 14-week Powerful Emotions group that integrates DBT skills, distress tolerance and emotion regulation should decrease BPD symptomology.

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Chapter III: Method

Participants
Archival data collected from 200+ clients involved in outpatient MPE groups conducted between May 2014 and May 2016 was used in the current thesis; however, only 53 had complete pre- and post-test data available and therefore were used in the analysis. The participants included in the thesis were aged 20-70 years, with an average age of 37.7 years (SD = 12.53). Both females (n = 44) and males (n = 9) were included. The MPE group was designed specifically for individuals diagnosed with BPD and all individuals with emotional regulation problems (i.e., those with and without a BPD diagnosis) were included. Individuals were not assessed for a diagnosis and therefore it was unknown how many participants had a diagnosis BPD. All participants were required to sign an informed consent and confidentiality form (Appendix A) at the beginning of the first group. It was unknown whether the participants were engaging in other forms of therapy at the time of the group, this factor did not affect the clients’ ability to participate in the group. The groups typically consisted of 10-to-15 members.

Setting
The setting of the MPE groups was the third floor of a six-story building. The floor consisted of three group rooms and six individual offices; the group took place in one of the group rooms. The groups on-set and offset time varied; however the session length was always 95-minutes.

Material
The facilitator provided weekly handouts that reviewed the information being covered that session. The participants were not required to bring writing utensils or other material, however, were informed notes could be taken if they wished. Seating for the participants was made available.

Design
The MPE group was based on Marsha Linehan’s traditional DBT group therapy (Linehan 1993) and was a modified DBT group consisting of weekly group sessions, one-on-one meetings (if needed), and weekly homework. The skills were taught by the facilitator; this form of delivery allowed for group discussion, questions, and effective dissemination of the information. The information provided was structured so that the participants were engaging in learning, listening, and active thinking during session. Many of the activities were homework based and promoted the therapeutic relationship, participation, learning, group cohesion, and comprehension of material. Within group activities allowed participants the opportunity to ask questions, share information, and receive feedback as well as clarification from the facilitator.

Measures
The Difficulties in Emotion Regulation Scale (DERS; Appendix D) and the Self-Assessment Questionnaire (Appendix B) were used as pre- and post-test measures. The participants completed both measures during the first week of treatment and during last week of treatment. The DERS has been adapted from Gratz and Roemer (2004) as a means to assess the multiple aspects of emotion dysregulation. The scale is a 36-item Likert (1 = “never”, 5 = “always”), self-report questionnaire that provides a total score as well as scores on six subscales that were derived through factor analysis in a previous study (Gratz & Roemer, 2004). The six subscales are: non-acceptance (non acceptance of emotional responses), goals (difficulties in engaging in goal oriented behaviour), impulse (impulse control difficulties), awareness (lack of
emotional awareness), strategies (limited access to emotional regulation strategies), and clarity (lack of emotional clarity; Gratz & Roemer, 2004). Higher scores indicate higher emotional dysregulation. The DERS is a useful measure and yields information necessary for determining one’s level of emotional functioning (Gratz & Roemer, 2004). The highest possible score for the DERS is 180 meaning high emotion dysregulation and the lowest possible score is 36 meaning emotional regulation. Correlations between the DERS and common symptoms associated with emotional dysregulation were found, demonstrating construct validity (Weinberg & Klonsky, 2009).

Weinberg and Klonsky (2009) conducted a study that included 428 participants, most of whom were female (n = 261). The individuals were aged 13-to-17-years-old and were comprised of Hispanic (19%), Asian (15%), Caucasian (53%), African American (11%), and mixed racial heritage (3%; Weinberg & Klonsky, 2009).

The Self-Assessment Questionnaire (SAQ) is an 8-item Likert (1 = “never”, 7 = “always”) scale developed by the agency staff for the MPE group. The SAQ meets acceptable internal reliability in the current sample (alpha = .75). The SAQ questions are designed to help the individuals evaluate their sense of control, comfort, and clarity over the emotions they experience. The highest possible score on the SAQ is 56 and the lowest possible score is 8. Higher scores indicate that the participant is better able to identify, cope with, and alter powerful emotions. SPSS was used to analyze the archival data for the present thesis.

Procedure

The MPE groups consisted of a total of 14-sessions, one session a week over the course of 14-weeks. Each session was 95-minutes in length and were run in groups ranging from 10 to 15 members. The sessions were comprised of homework discussion, dissemination of material, group discussions, and examples. Each session was delivered using a combination of weekly handouts and verbal examples given by the facilitator.

The structure of the group was 20-to-30-minutes of homework review, 40-to-45-minutes of information delivery, and 10-to-15-minutes of discussion and homework explanation. Time spent on each of these varied from session to session, depending on the size of the group, amount of new material, information comprehension, and group involvement. The first 6-weeks of the group was targeted towards teaching distress tolerance skills. Two sessions were used as introductions to groups that could be taken after MPE was completed, Mindfulness and People Skills. The remaining 5-weeks was focused on emotion regulation, how dysregulation occurs, what it is to be regulated, how regulation is affected, and skills that can be used to achieve regulation. Appendix C presents a weekly schedule of material delivery of the 14-week MPE group.
Chapter IV: Results

It was hypothesized that the use of a 14-week MPE group treatment that focused on distress tolerance and emotion regulation would decrease participants’ scores on the DERS and increase scores on the SAQ from pre- to post-testing.

Preliminary Data Analysis

The DERS was assessed in terms of internal consistency, validity, and normal distributions. The DERS had a high internal consistency (alpha = .93). Outliers are defined as three standard deviations away from the mean; all participants were within three standard deviations from the mean on dependent variables. In order to evaluate normal distributions histograms and skewness were examined, histograms showed normal distribution and skewness was normal for the DERS (skew = -.157 to .100).

The SAQ was assessed in terms of internal consistency, validity, and normal distributions. Outliers are defined as three standard deviations away from the mean; all participants were within three standard deviations from the mean on dependent variables. In order to evaluate normal distributions histograms and skewness were examined, histograms showed normal distribution and skewness was normal (skew = -.157 to .100). Histograms were evaluated and SAQ distributions were assessed as normal.

The participants ranged between 20 years to 70 years old with an average age of 37.77 (refer to Figure 1.0 for a graph of participant age). The education and ethnic background of the participants was not assessed for the present thesis. Out of the 53 participants nine (16.9%) were male and 44 (83.0%) were female (refer to Figure 1.1 for a graph of participant sex). Participants’ scores on the pre-DERS ranged from 67.00 to 164.0 (M = 119.70). The post-test DERS scores ranged from 46.00 to 160.00 (M = 96.15). Participants’ scores ranged from 10.00 to 41.00 with an average score of 25.38 on the pre-SAQ. The post-SAQ scores demonstrate scores ranging from 13.00 to 48.00 (M = 32.62).
Figure 1.0. Graph displaying the age distribution of the participant’s.
Figure 1.1. Bar graph representing the number of females and males.
DERS

A paired sample t-test was conducted to evaluate the impact of the MPE group on pre- and post-test scores on the DERS. The archival data was assessed and met the assumptions of a paired sample t-test. That is, treatment conditions are independent of each other and distributions are normal. According to Cohen’s (1998) standards, there was a significantly large decrease in DERS scores from pre-testing (M = 119.69, SD = 25.17) to post-testing (M = 96.15, SD = 8.49; t(52) = 6.77, p < .001, d = .96 (two-tailed), demonstrating a large effect size (refer to Figure 1.2. for a visual of pre- to post-testing averages for the DERS). The lowest possible score for the DERS is 36, indicating high emotional stability. The average score for participants at pre-treatment testing was 119.69 and was 96.15 at post-treatment testing, which results in a pre- to post-test average score decrease of 23.54. On average participants scored high on the lower range of the DERS post-treatment. It is unlikely that participants scored lower on the DERS post-treatment by chance; therefore, the MPE treatment demonstrates clinical significance.
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Figure 1.2. Bar graph displaying the participant’s average scores for the DERS

Figure 1.2. Bar graph displaying the participant’s average scores for the DERS.
SAQ

A matched samples t-test was conducted to evaluate the impact of the MPE group on member’s self-assessment of their ability to identify and cope with emotions. According to Cohen’s (1998) standards, there was a significant large increase in SAQ scores from pre-testing (M = 26.42, SD = 8.49) to post-testing (M = 31.50, SD = 7.76, t(41) = -2.61, p < .001, d = 0.62 (two-tailed), demonstrating a medium to large effect size. The SAQ scores from pre- (M = 26.42) to post-testing (M = 31.50) increased by a score of 5.08, despite the small increase the average increase nonetheless. However, since the SAQ was developed by the agency facilitating the MPE treatment it is not possible to state whether participants’ are in the low, medium, or high range of scores. The increase in the average score indicates a level of clinical significance as a result of the 14-week MPE treatment (refer to Figure 1.3 for a visual of pre- to post-testing participant averages for the SAQ).
Figure 1.3. Bar graph displaying the participant’s average scores for the SAQ from pre- to post-testing.
Chapter V: Discussion

**Strengths**

Strengths of the thesis include that it can be implemented among individuals who are diagnosed with BPD as well as those who struggle with emotion regulation without meeting the criteria. The thesis sample group was comprised of men and women, although the number of males included in the thesis was small it may still indicate that the MPE group treatment can be implemented effectively with both sexes. The thesis had a sample size of 53 participants, which is a reasonable sample to analyze. Of the 53 participants 44 (83.0%) were female, indicating that the results of the thesis can be generalized to females outside of the thesis. Another strength of the thesis was that the data was relatively easy to analyze and the results supported the proposed hypothesis. The staff that facilitated the MPE groups included in the thesis, had a Masters level of education. Due to the fact that the facilitators were well educated, experienced, and confident most likely had an effect on the effectiveness of the group treatment. Another strength of the thesis was the agencies’ dedication to ensure client confidentiality and privacy through the use of consent forms and confidentiality forms. The staff also ensured client safety at all points throughout the treatment. The thesis was effective in terms of accuracy, data appeared normal in terms of distributions and the correct research design was selected.

**Limitations**

The present thesis presented several limitations. The main limitation being that there was no control group with which to compare the findings of the treatment group to. Another limitation of the thesis was that the sample size of 53 participants only consisted of nine males (16.9%), and therefore it is not possible to state confidently that the MPE group can be generalized to other males outside of the sample size. Another limitation was that finding literature that used and reported results from the DERS were difficult to find, which made it difficult to compare the results of this thesis to that of others. The thesis did not analyze the six subscales of the DERS individually; the average total scores were used to identify changes from pre- to post-testing. It is possible the average scores were not robust enough to offer specific explanations about where the major changes occurred for participants’ whereas analysis of the six subscales could have provided further information. In the past the agency has offered the MPE group online, however, due to time restraints the data from the online groups were not able to be included in the thesis. Therefore, it is not possible to state whether the online version produces similar significant results. Since discussing traumatic and graphic experiences can be triggering to other group members, participants are required to sign a consent form stating that such traumatic events should not be shared. The inability to share these personal events may have hindered some individuals from receiving the full benefits of the therapy and may have led to client resistance during therapy. Client motivation can often become a barrier to effective treatment as well as access to transportation. It was observed when collecting data for the analysis that many of the pre- or post-tests were not competed by the clients. It is possible that the agency could be more adamant about test completion, this would allow for a larger amount of useable data and a larger sample size. Conducting group therapy is a concern as attrition is common. It was noted that many individuals completed a pre-test but not a post-test, indicating either attrition or negligence.

**Multilevel Challenges to Service Implementation**

All of the data used in the current thesis was archival and therefore the researcher was not able to observe the participants during group therapy, however, challenges at the client level were still present. Although facilitators administered pre- and post-tests accompanied by clear
instructions, many of the archival tests were not completed. These included missing questions, dates, and identifying information. The current thesis included pre- and post-test from 53 participants over the course of three years, considering the fact that the agency offers the MPE group 5 or 6 times throughout the year with about 15 people in each group, there should have been a larger amount of tests to include in the thesis. A larger sample size would increase the reliability and validity of the analysis. It is possible that clients that did not complete the measures were unknowingly expressing resistance.

Based on verbal feedback from the facilitators it was determined that the participants offered positive feedback about the MPE group. However, facilitators noticed that around week seven the attrition rate usually increases. During week seven participants received an introduction to People Skills, a community group offered by the agency, and the following week is an introduction to Mindfulness, another community group offered by the agency. The gap between distress tolerance strategies and emotion regulation training may have been too long and could have been the reason for the increase in attrition rates. Excluding the People Skills and Mindfulness introduction sessions might produce a favourable affect on attrition rates.

The increased prevalence of BPD and the urgent need to provide treatment, clinicians continue to hesitate to offer treatment to the borderline population due to the discomfort of working with the high-risk behaviours and intense emotion dysregulation typical of this population (Dixon-Gordon et al., 2016). The development of DBT in 1993 has allowed clinicians to have a better understanding of BPD and emotional dysregulation in general enabling agencies and clinicians to offer treatment for individuals with high-risk behaviours and emotion dysregulation. However, many agencies and clinicians are still not trained in DBT and therefore unable to provide the appropriate service for the growing population. The Personality Disorder Services in Kingston offered DBT group treatments to individuals in Kingston and the surrounding area. Such a largely populated area creates a long waiting list for individuals seeking treatment. One challenge is the inability to provide service to all individuals in a timely manner, despite the best efforts of agencies and clinicians. The need for DBT trained clinicians remains a challenge for organizations seeking to provide treatment for individuals with high-risk behaviours such as BPD.

Mental health awareness has been growing rapidly in the last few years however a lot of stigma still surrounds it. Providing treatments to individuals who are anxious or afraid to seek it out is challenging. Continuing to promote acceptance and awareness about mental illness as a means to lessen the stigma proves to be a challenge that all of society must tackle.

**Results**

The results of the thesis indicated that the use of a 14-week MPE group that teaches distress tolerance and emotion regulation skills was effective when the target was to increase individual’s sense of understanding and control over their emotions. On average participants’ scores on the SAQ increased from pre- to post-testing and decreased on the DERS from pre- to post-testing.

**Implications for the Behavioural Psychology Field**

The current thesis results were similar to those published in the literature examining DBT treatments for BPD or undiagnosed individuals with emotion regulation difficulties. This contributes to the efficacy and effectiveness of DBT treatment for emotional regulation problems. Ensuring that treatments are empirical and effective for the target population is a core principle in the Behavioural Psychology field. Whether clients require treatment for developmental disabilities, acquired brain injuries, addictions, or psychological pathologies
access to feasible and empirically based treatment for emotion dysregulation is beneficial for clinicians within the behavioural psychology field.

**Recommendations for Future Research**

Future research could include the use of a control trial in order to strengthen research results. The inclusion of an online MPE group would also increase treatment fidelity and efficacy. Thirty-five or 66.03% of participants’ were aged between 31 and 70 years old, while only eighteen or 33.96% of participants were 30 years or younger. Emotional dysregulation usually starts at a young age as it is the result of both the innate temperament of the child and the environment that child was raised in (Linehan, 1993). Therefore implementing an MPE group with younger individuals, aged 14 to 30 years old, would most likely produce significant reductions in the amount of adults seeking treatment for emotion regulation, while allowing for the ability learn to identify and cope with intense emotions at a younger age.

**Conclusion**

BPD is marked by fear of abandonment, chronic feelings of emptiness, recurrent suicidal behaviours, impulsivity, identity disturbances, and affective instability (American Psychiatric Association, 2013). Affective instability encompasses, poor distress tolerance, emotion regulation, and interpersonal skills. Linehan (1993) developed DBT as a means to teach individuals with BPD distress tolerance, emotion regulation, and interpersonal skills. The current thesis hypothesized that the implementation of a 14-week MPE group with a focus on distress tolerance and emotion regulation would be effective at increasing participants’ scores on the SAQ and decreasing scores on the DERS. The results of the analysis prove the hypothesis; on average DERS scores decreased while SAQ scores increased. The use of DBT skills has increased over the last decade, this thesis adds to the expanding literature demonstrating the fidelity and efficacy of a DBT skills based group with individuals with BPD or emotional dysregulation. MPE teaches distress tolerance skills as a means to cope with intense emotions, often these distress tolerance skills require engaging in behaviours that are not going to make the situation worse (i.e. self-harm behaviours), therefore altering behaviour. Emotional instability is a common feature in many developmental disabilities and pathologies; this thesis provided further evidence to support an empirically based treatment with the core focus on changing maladaptive behaviours as a means to increase overall quality of life for individuals.
MANAGING POWERFUL EMOTIONS

References


Appendix A
Informed Agreement

Consent Form
Electronic Managing Powerful Emotions (E-MPE)
And Managing Powerful Emotions (MPE)

Study Title: Dialectical Behavioural Therapy by E-mail.

BACKGROUND INFORMATION: You are being invited to participate in a research study directed by Dr. Nazanin Alavi and Dr. Margo Rivera to evaluate the usefulness of Dialectical Behavioural Therapy provided by E-mail as compared to Dialectical Behavioural Therapy offered in a live group. This study has been reviewed and approved for ethical compliance by the Queen’s University Health Sciences and Affiliated Teaching Hospitals Research Ethics Board.

DETAILS OF THE STUDY: Managing Powerful Emotions (MPE) Group is a psycho-educational group offered for individuals who experience challenges in emotion and behavior regulation. If you consent to take part in this study, you will participate in either the online format or in the live group sessions, each a 12-week program. Before the first group session and after the last session you will be asked to fill out a “Self-assessment Questionnaire” and a “Difficulties in Emotion Regulation Scale” (DERS) questionnaire.

If you participate in the online format, you will be sent general information about a particular topic electronically each week, an overview on helpful skills, and homework assignment sheets. This material will directly correspond with the material provided in the live group session that is carried out at the Personality Disorders Service, Providence Care - Mental Health Service. If you participate in the live group, you will attend weekly sessions at the Personality Disorders Service site at 303 Bagot Street, Suite 300, in the LaSalle Mews in downtown Kingston, for a one and one-half hour time period.

BENEFITS: E-MPE -- If you are experiencing difficulties with emotion and behavior regulation and are looking for help, but you do not wish to participate in groups, do not have the time during the day, or transportation to the group site is a problem for you, you will have the opportunity to learn the Dialectical Behavioural Therapy techniques by email.
MPE -- If you participate in live group, you have the opportunity to attend a live group to learn Dialectical Behavioural Therapy skills and to contribute to a study that may benefit other people struggling with a range of emotional and behavioural problems to have access to Dialectical Behavioural Therapy in an electronic modality in the future.

ATTENTION: Neither the MPE or the E-MPE Group is structured to intervene directly in any crisis that may arise in the lives of the group participants. In the Electronic Managing Powerful Emotions (E-MPE) group, the facilitator receives and reads the group members email on a specific day. Therefore, if you are in crisis during the week, please do not send an email to the facilitator regarding your crisis. Both groups are designed to help people learn basic skills that enable them to manage their own emotional crises and enhance their ability to build stable and productive lives. They have not been designed to deal with emergencies. So if you are in a crisis that you are not able to handle by yourself, please go to your local emergency room, call a crisis line for support, or contact your family doctor. Your group facilitator is not in a position to help you directly during a crisis.

CONFIDENTIALITY: All information obtained during the course of this study is strictly confidential, and your anonymity will be protected at all times. All the participants in both groups will have a research file and a clinical file. All emails that are sent to the facilitator by E-MPE participants and all the replies will be printed and put in your research file, and the original emails will be deleted. The facilitators of both the MPE and E-MPE groups will write a note regarding the participation of each group member after every session; this note will be placed in your clinical file. Only Dr. Alavi, and Dr. Rivera, the group facilitators and their supervisor, have access to your research file and only staff at the Personality...
Consent Form

Disorders Service involved in your care have access to the clinical file as per Personality Disorders Service confidentiality policies. You will be identified by an identification number in the data from this study, and the data will be saved without mention of your name. Data will be stored in locked files and will be available only to Dr. Alavi and Dr. Rivera. You will not be identified in any publication or reports.

**VOLUNTARY NATURE OF THE STUDY:** Your participation in this study is voluntary. You may withdraw from this study at any time, and your withdrawal will not affect your future medical care.

**WITHDRAWAL OF PARTICIPANT BY FACILITATORS:** The group facilitators may decide to withdraw you from this group/study if it is their assessment that the group is not of benefit to you.

I have read and I understand the consent form for this study. I have had the purposes, procedures and technical language of this study explained to me. I have been given sufficient time to consider the above information and to seek advice if I chose to do so. I have had the opportunity to ask questions, and any questions I have asked have been answered to my satisfaction. I am voluntarily signing this form. I will receive a copy of this consent form for my information.

If at any time I have further questions, problems, or adverse events, I can contact Dr. Nazanin Alavi at 613-548-2473 or Dr. Margo Rivera, Clinical Leader, Personality Disorders Service at 613-542-8344.

If I have additional questions regarding my rights as a research participant, I can contact Dr. Albert Clark, Chair, Queen’s University Health Sciences and Affiliated Teaching Hospitals Research Ethics Board at 613-533-6081.

By signing this consent form, I am indicating that I agree to participate in this study.

Signature of Participant ______________________ Date __________

Signature of the person explaining the consent process ______________________ Date __________

**STATEMENT OF INVESTIGATOR:**
I, or one of my colleagues, have carefully explained to the participant the nature of the above research study. I certify that, to the best of my knowledge, the participant understands clearly the nature of the study and demands, benefits, and risks involved to participants in this study.

Signature of Principal Investigator ______________________ Date __________
Appendix B
Self-Assessment Questionnaire (SAQ)

(PRE / POST)
(please circle which one)

Date: ____________________________  Initials: ___________  MRN: ___________
dd/mmm/yyyy

Self-Assessment Questionnaire
We would like to know how well you deal with the following areas of your life. Please write down the number that best reflects your ability using the following scale

1 2 3 4 5 6 7
Very Poorly............................ Extremely Well

1. How well do you think you understand your emotions? ___

2. How well are you able to identify (name) the emotions that you feel? ___

3. How well do you think you control your behaviour when you have strong emotions? ___

4. How well do you manage healthy eating, sleep routines, exercising, taking care of physical illnesses, avoiding mood-altering drugs, etc.? ___

5. How well are you able to identify what causes you to have an emotion (an event, a thought, etc.)? ___

6. How well do you accept your emotions, even when they are painful? ___

7. How well are you able to experience, and hang on to, positive emotions (joy, happiness etc.)? ___

8. How well do you tolerate your distressing or upsetting emotions? ___
### Appendix C
14-Week MPE Weekly Schedule

<table>
<thead>
<tr>
<th>Week #</th>
<th>Session Material</th>
</tr>
</thead>
</table>
| 1      | Orientation  
|        | Goals of Distress Tolerance  
|        | Accepting vs. Willfulness  
|        | Introduction To Distress Tolerance  |
| 2      | Crisis Survival Strategies  
|        | - Distract  
|        | - Self-soothe  
|        | - Improve the moment  |
| 3      | Crisis Survival Strategies  
|        | - Pros and cons of Tolerating Distress  |
| 4      | Acting Opposite To the Current Emotion  |
| 5      | Skills for accepting life as it is in the moment  
|        | - Half Smile  
|        | - Mindful Breathing  |
| 6      | Reflection on Distress Tolerance Box  |
| 7      | Introduction to People Skills  |
| 8      | Introduction to Mindfulness  |
| 9      | Goals of Emotion Regulation Training  
|        | Decreasing Vulnerability to Painful Emotions  
|        | Increasing Pleasant Events  |
| 10     | Emotion Regulation  
|        | Emotion Dysregulation  
|        | Emotion Modulation  
|        | Two Kinds of Emotional Experiences  |
| 11     | Functions of Emotions  |
| 12     | Emotion Regulation Homework  |
| 13     | Emotion Regulation Homework Review  |
| 14     | Review  
|        | Discussing Post Group Opinions  |
Appendix D
Difficulties in Emotion Regulation Scale (DERS)