

Dialectical Behavior Therapy: A Visual Review Part 1.

A Visual Review



Part 1

- ⌘ This presentation plays automatically.
- ⌘ The following portion of this presentation will cover:
 - Borderline Personality Disorder Basics
 - Dialectical Behavior Therapy Basics
 - Individual Therapy
 - and Dialectical Dilemmas
- ⌘ The next presentation (Part 2 of Dialectical Behavior Therapy: A Visual Review) covers Skills Training in DBT.
- ⌘ Played on auto with narration, Part 1 is 47 minutes in length and Part 2 is 45 minutes.
- ⌘ Alternatively, you may print the notes pages, turn off narration, and go through the slides manually at your own pace.

This project is supported by a grant through:

- Department of Veterans Affairs, South Central Mental Illness Research, Education, and Clinical Center (MIRECC), 2015.



The image displays three book covers and the MIRECC logo. The first book, 'Cognitive-Behavioral Treatment of Borderline Personality Disorder' by Marsha M. Linehan, has a red and black cover. The second book, 'DBT Skills Training Manual' (Second Edition) by Marsha M. Linehan, has a blue cover. The third book, 'Doing Dialectical Behavior Therapy: A Practical Guide' by Kelly Koerner, has a green and yellow cover. The MIRECC logo features a map of the South Central region of the United States with the text 'South Central MIRECC' and 'Mental Illness Research, Education & Clinical Center' below it.

This project was made possible by a grant through the South Central Mental Illness Research, Education, and Clinical Center.

Dialectical Behavior Therapy is a very complex and multifaceted therapy for Borderline Personality Disorder and other complex diagnoses. This training is meant to use visual methods to provide a simple overview of DBT in order to provide clinicians with a general knowledge of the therapy. If you are interested in becoming part of a full DBT Team please seek further information through: Behavioral Tech, LLC.

This training is based on the DBT program at the Central Arkansas Veteran's Healthcare System, different programs will vary throughout settings and populations as needed. The concepts and theories within originated in Dr. Marsha Linehan's writings including her 1994 book "Cognitive-Behavioral Treatment of Borderline Personality Disorder" and the companion book, the second edition of the "Dialectical Behavioral Therapy Skills Training Manual" published in 2015. Other experts in the field, particularly Dr. Kelly Koerner, have been consulted regarding content and wording. You can find citations and sources at the end of the presentation.

Meet the Presenters



Stephanie Johnston, LCSW



Dr. Steve McCandless, PsyD



KEVIN CATES DESIGN

Graphic Design by artist: Kevin Cates
(www.kevincatesdesign.com)



Stephanie Johnston is a Licensed Clinical Social Worker here in the Mental Health Clinic at the Little Rock Arkansas VA. She provides individual, family, and group therapies using a variety of theories. She's been through formal training in DBT and has been on our DBT team here for 2 years. She currently co-lead a DBT skills group and provides individual therapy and skills coaching in DBT.

She has a background in the arts and has always been interested in using visual devices to better communicate some of the more abstract concepts found in therapy. Last year through MIRECC she made animated videos to help explain the primary concepts within Acceptance and Commitment Therapy (which can be found on TMS and the national VA youtube page). That project went well so we decided to apply the concept this year to Dialectical Behavior Therapy. This presentation is the result of our collaboration with local graphic design professor and artist Kevin Cates. We hope that the presentation will help clinicians better understand some of the concepts within DBT. The graphics are also available at the end of the presentation to assist clinicians in better explaining concepts to DBT clients.

I'm Steve McCandless, a psychologist at the Central Arkansas Veterans Healthcare System in Little Rock Arkansas. I have attended formal DBT training and have been a member of the CAVHS DBT team since 2007. Most recently, I was a DBT skills champion providing phone coaching for the implementation of DBT skills in the VISN 16 CBOC's.

The CAVHS DBT Team



Central Arkansas Veterans Healthcare System

The CAVHS DBT team formed in 2007 with a MIRECC grant that provided initial funding for a full time DBT team coordinator and 2-week intensive training with Behavioral Tech-the main supplier of DBT training and materials. Currently the team consists of 2 psychiatrists, 3 psychologists, 3 social workers, and a medical resident. The team meets weekly for an hour long consultation team meeting where cases are reviewed. The team provides weekly individual psychotherapy and weekly group psychotherapy where coping skills are taught. At any given time there are approximately 12 patients enrolled in the program. They are typically in the program for one year. In addition to offering traditional DBT therapy, patients may also attend a group where there is no ongoing individual psychotherapy required. We also provide a maintenance group for graduates of the program.

In this brief training we will review

- the basics of Dialectical Behavior Therapy;
- the BioSocial Theory that it's based on and the basic format of therapy;
- the general philosophy of the Dialectical Dilemmas and Six Secondary Targets;
- and a skills training component from each of the four skills modules:
 - Emotion Regulation, Interpersonal Effectiveness, Distress Tolerance, and Mindfulness.



DBT is especially well suited for individuals with Borderline Personality Disorder, which we'll abbreviate as BPD. Let's start by covering some of the basics of the diagnosis.



Borderline Personality Disorder is primarily a disorder of mood dysregulation. In contrast to individuals with Bipolar Disorder or Depression who may have episodes of intense sadness, anxiety, or euphoria lasting days to weeks, individuals with BPD tend to have a mood that fluctuates much more rapidly. They experience intense mood states lasting minutes to days which are often triggered by a person or event. Because of this they are sometimes described as having a very reactive mood. They also may express anger frequently, which is thought to often be a way of covering up more painful emotions such as shame and fear. They tend to have a very unstable sense of identity. They may be unaware of their likes and dislikes or they may describe themselves as social chameleons, having shifting tastes and ways of acting depending on the people they are around in the moment. Their reactive mood states make it difficult to maintain relationships and they may be particularly sensitive to signs of rejection and abandonment. Intense feelings may lead to impulsive behaviors to alleviate their negative mood states. Perceived abandonment by others might also result in drastic behaviors. Often intense shame and guilt may lead to suicidal behaviors. Self-harm or parasuicidal behaviors often occur as well. Patients offer various explanations for these behaviors such as being attempts to distract themselves from painful emotions; that the behaviors offer a way of “snapping-out-of-it” when patients feel out of touch with reality or are dissociating; and others describe self harm as a means of feeling something when they feel emotionally numb.

Borderline Personality Disorder

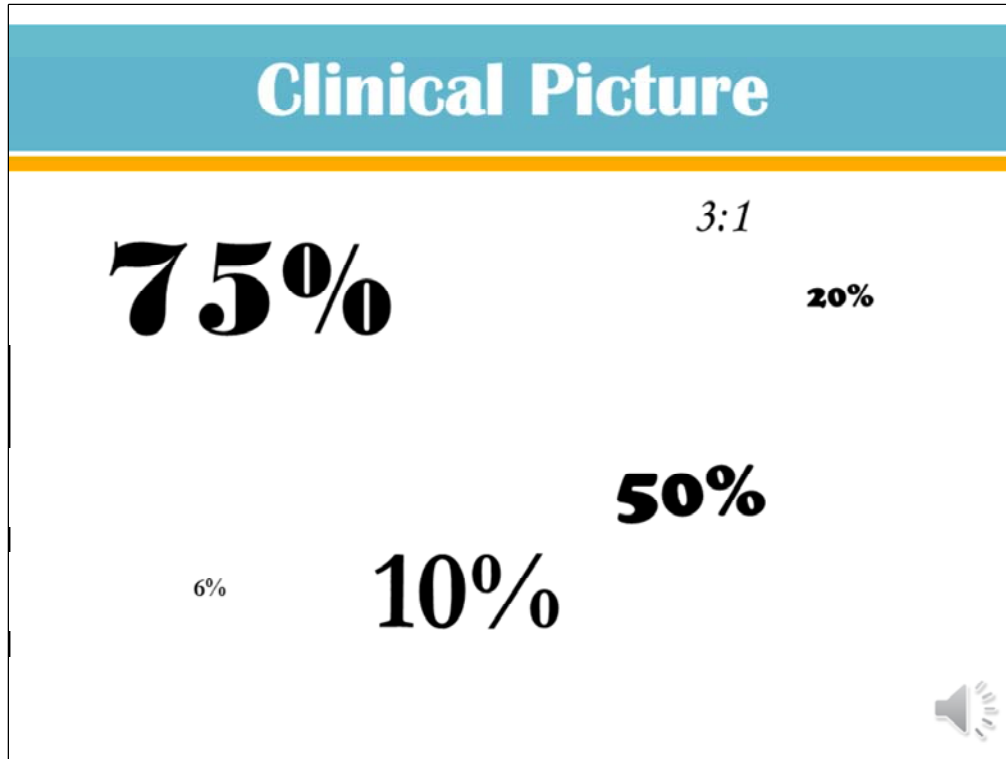
1. Fear of abandonment
2. Chaotic relationships
3. Identity disturbance
4. Impulsivity
5. Suicidal or self-harm
6. Mood instability
7. Feelings of emptiness
8. Intense anger
9. Stress-related paranoia or dissociation

5 of 9



The 5th Edition of the Diagnostic and Statistical Manual of Mental Disorders states that BPD is characterized by “A pervasive pattern of instability of interpersonal relationships, self image and affects, and marked impulsivity beginning by early adulthood and present in a variety of contexts.” It lists 9 criteria associated with BPD of which an individual must demonstrate 5 for a diagnosis.

In our skills groups or in individual therapy I like to go over these 9 points with clients to help them better understand the diagnosis and to reduce some of the shame and stigma associated with the diagnosis. We’ll discuss shortly how these 9 criteria are seen through the lens of DBT.



So what does BPD look like in the clinical picture?

In 2010 Samhsa provided Congress with a report on BPD, these are some of the figures found within it:

- One of the clinical hallmarks of the disorder; **75%** of individuals with BPD self injure.

“From a 2008 study it was found that BPD is much more prevalent in the general population than previously recognized and surprisingly it’s nearly equally prevalent among men and women”

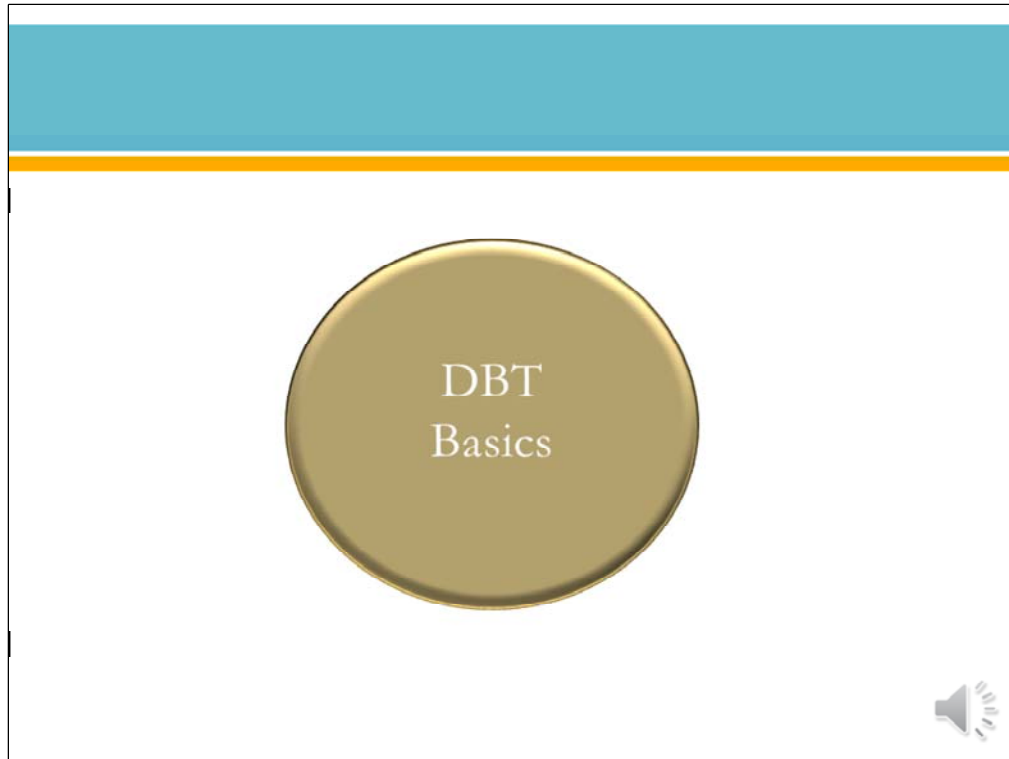
- **6%** of the population are the current estimates.
- Females are diagnosed **3:1** to males, though males are underdiagnosed.

The five of nine criteria needed to diagnose BPD can be combined in many different ways, resulting in individuals who present very differently although they’re all struggling with similar issues. In a skills group you may have 6 very different clients at first glance but on further review they are all surprisingly similar.

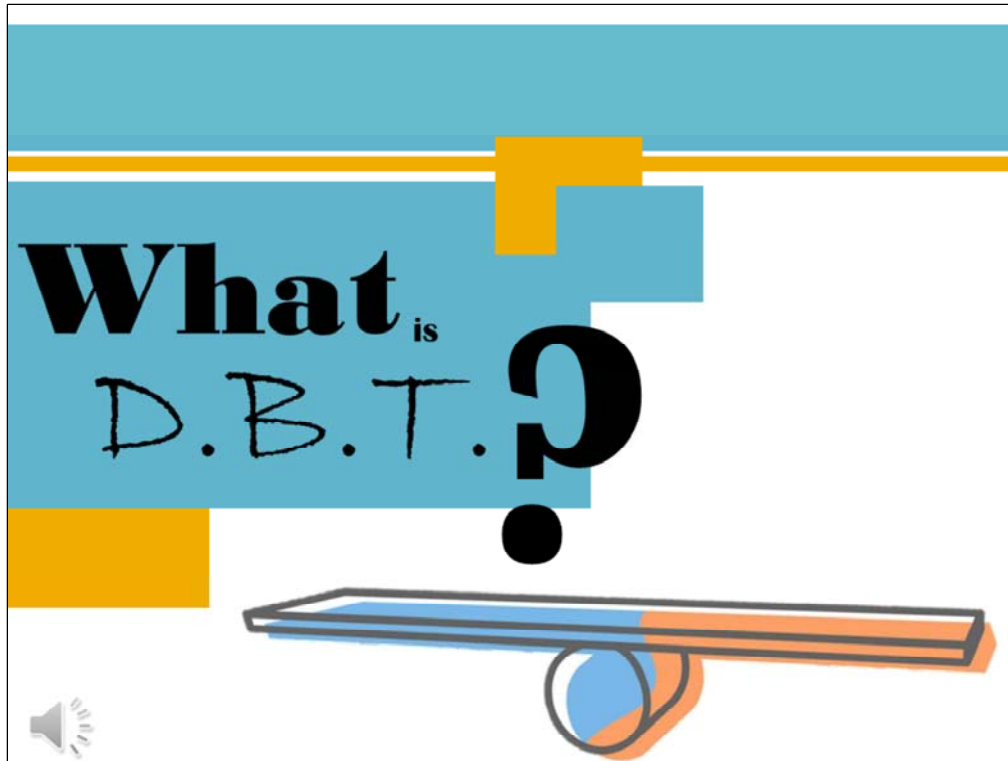
- BPD affects **50%** more people than Alzheimer’s disease and nearly as many as schizophrenia and bipolar combined (2.25%). (National Education Alliance Borderline Personality Disorder.)

- BPD affects **10%** of clients in outpatient care and **20%** of those on inpatient mental health units

These clients are notoriously hard to treat and the burnout rate for clinicians is high. Meanwhile we find that our BPD clients are some of those suffering the most. At CAVHS we've been using DBT to treat these difficult cases for the past 8 years. Our clinicians have come to really appreciate how effective the therapy is in managing both the clients' symptoms as well as the clinician's stress.



Now that we've reviewed the basics of BPD, let's look in depth at Dialectical Behavior Therapy and how it helps.

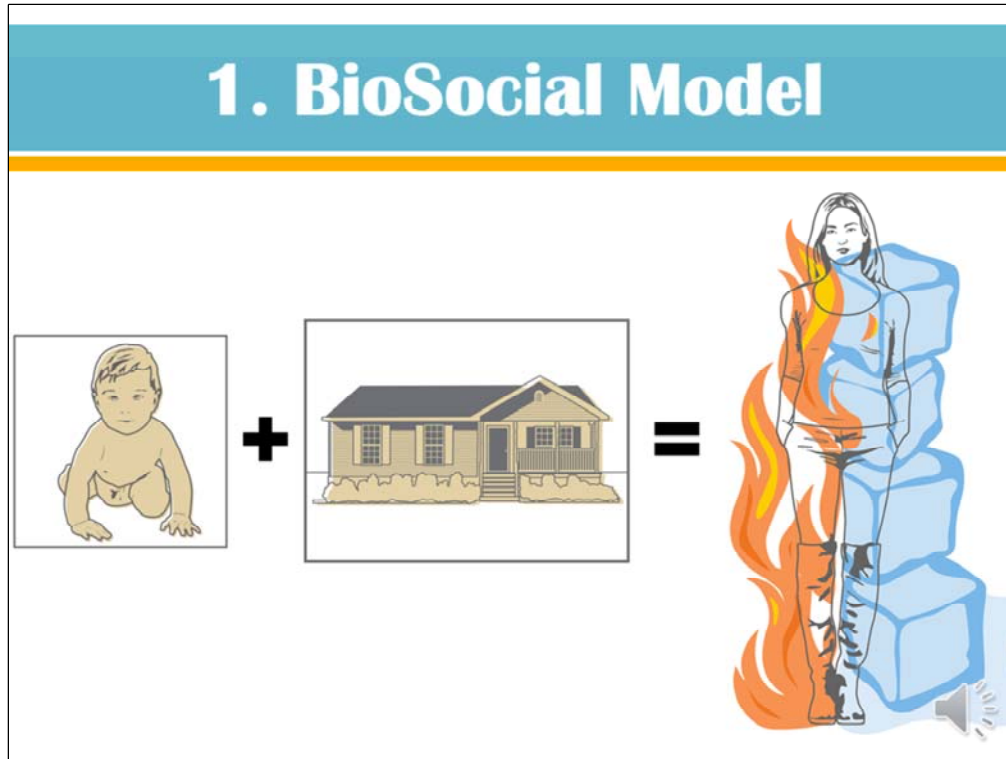


Dialectical Behavior Therapy or DBT for short was developed by Dr. Marsha Linehan a psychologist and researcher associated with the University of Washington. Early in her career she recognized that there were not many effective treatments for patients with chronic suicidality. Needing a specific population of patients to study that demonstrate frequent recurring suicidal behaviors she began developing treatments targeting Borderline Personality Disorder. She tried applying techniques of person-centered therapy such as validation and empathy but found that these methods did little to encourage patients to change problems in their life that were causing their suffering. She also applied problem-solving and behavioral strategies that emphasized making changes in oneself and the environment, but patients felt misunderstood and experienced shame that they were the causes of their suffering, which led to increased suicide risk. Dr. Linehan's unique approach was to combine both person centered (acceptance) strategies with behavioral (change) strategies and incorporate the Zen Buddhist principles that are now often referred to as Third Wave Cognitive Behavioral therapy such as mindfulness and dialectics. Dialectics refers to the underlying assumption in DBT that opposite ideas can be combined to come up with a more balanced and indeed a more accurate view of reality. One of the main dialectics in DBT is that a patient both needs to fully accept themselves while at the same time understanding that they must change.

In the last 20 years, the growing body of evidence suggests that DBT may be effective for many psychological disorders that demonstrate problems with emotion dysregulation. In particular, research suggests it is an effective treatment for Substance Use Disorders and

Eating Disorders. Often times DBT strategies are needed to get patients with PTSD to a point where they can handle the emotional intensity associated with exposure therapy.

In addition to providing the unique perspective of balancing change and acceptance strategies, DBT is useful in structuring targets for treating complex cases as is often the case with patients presenting with Borderline Personality Disorder. In traditional therapeutic approaches it can be difficult to make lasting change in patients presenting with BPD because sessions are spent focusing on whatever crisis has recently brought the patient to a point of emotional distress and decompensation. In DBT there is a specific hierarchy of topics that can be discussed. This structure is strictly enforced and agreed upon by the patient prior to starting therapy. First only suicidal and para-suicidal behaviors are addressed in session. Second, therapy interfering behaviors are addressed such as missed sessions, not discussing important information or symptoms, or behaviors in session that are inappropriate. Lastly, quality of life interfering behaviors are addressed in session such as drinking, promiscuity etc. that are not immediately life threatening but must be managed in order to “build a life worth living.”



Who develops BPD?

Through her work with intensely suicidal patients, Dr. Linehan began to understand that there were often common themes running throughout their histories. She developed the BioSocial model which helps clients understand that their reactions to the stressors in life make complete sense in the context of their biological and social worlds. When introducing DBT to clients who are entering our program we describe the biosocial model to them in this way. It helps them to both make sense of the struggles they've endured while also reducing a sense of shame and guilt.

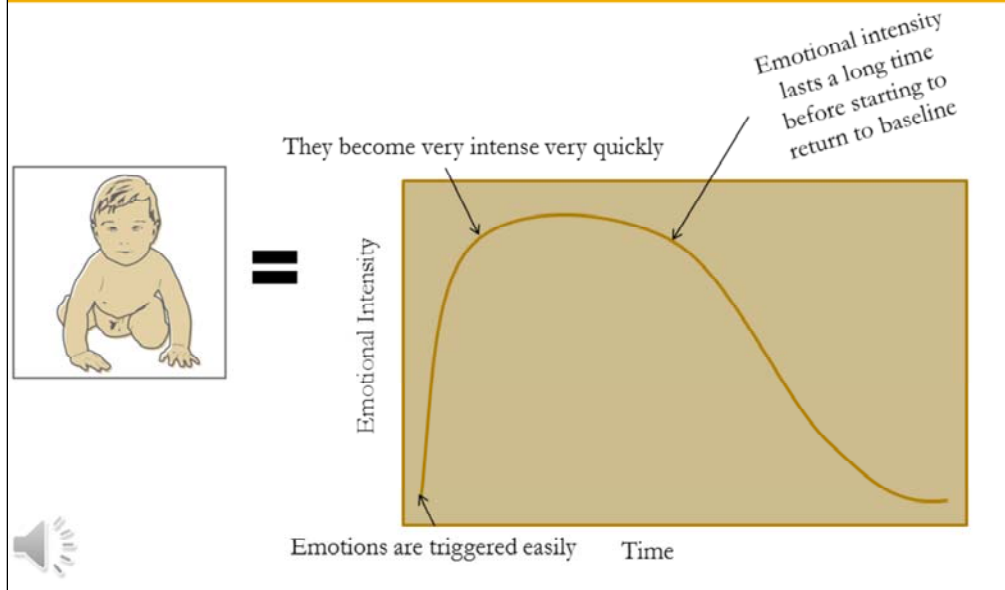
The BioSocial model posits that: Someone with BPD was born as a very sensitive baby. They came straight out of the womb with intense emotions. This is neither a good nor bad thing necessarily. People who have the capacity to feel strong emotions are some of our best artists, poets, actors, or caregivers. They make the world a more interesting and better place; unfortunately they can also be some of our most distraught individuals if they don't learn how to properly manage those emotions. So we've got this itty bitty baby who is very emotionally intense. When they're sad they're in despair; scared they're terrified; angry-furious; and if they're happy they're overjoyed.

The problem comes in when this baby is born into an invalidating environment. Now invalidation can come about in a variety of ways. The most obvious source would be neglect or an either sexually, physically, or emotionally abusive environment. It could be

that parents and children are simply a poor fit for one another, or it could also be a school or social environment that is invalidating. Whatever the source, the child has incredibly intense emotions but due to invalidation is not taught what these emotions are, or how to deal with them. They are confused because they feel sad but are not taught what sadness is, or they are taught that sadness is not ok. This sets up a struggle within themselves, and causes them to learn (often destructive) ways to cope on their own.

So these two factors, the nature and the nurture, combine together to create an adult with Borderline Personality Disorder. BPD is the way in which that individual has figured out how to manage their unregulated intense emotions. Going back to the 9 criteria: fear of abandonment, identity issues, and unstable relationships can be seen as the individual using others to gauge how they themselves should be. Impulsivity, suicidality, and dissociation can be seen as means in which to bring emotional intensity up or down. And the mood instability and intense anger are direct expressions of those biologically intense emotions running wild without the socially learned coping skills needed to regulate them.

Sensitive Baby

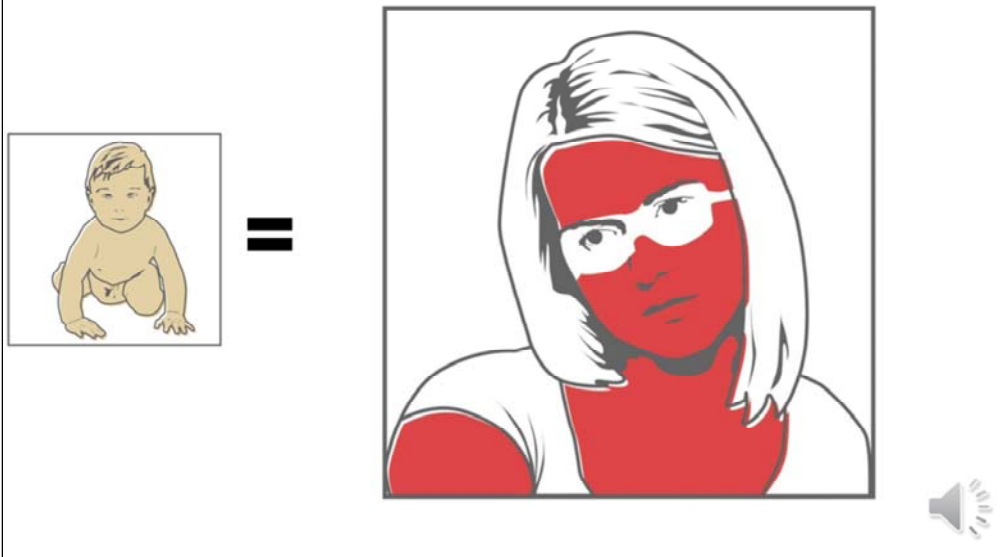


In an individual with BPD, emotions are triggered very easily.

Their emotional reactions are extreme and happen fast. Anger is rage, joy is elation, sadness is despair.

Emotional reactions are long lasting with a slow return to an emotional baseline. What might be resolved in minutes for most individuals might take days for an emotionally vulnerable individual. Again, this graph is something we show our clients in order to help them better understand themselves and the way in which they interact in the world.

Emotional Burn Victim



This emotional intensity without learned coping skills leaves individuals with an inability to withstand much distress before resorting to unhealthy means of regulating their emotions. (ie self harm, drug or alcohol use, impulsive behavior)

Dr. Linehan has described individuals with BPD as “emotional burn victims”. She notes that their tendency to be overwhelmed by their internal emotional states is metaphorically similar to the sensitivity of burn victims to the slightest touch. What others’ may perceive as a slight emotional trigger is to them incredibly painful and distressing. This sensitivity can also lead to continued invalidation, as others often believe that the individual is being dramatic or manipulative when they express an intense reaction to a seemingly minor stimulus.

Invalidating Environment

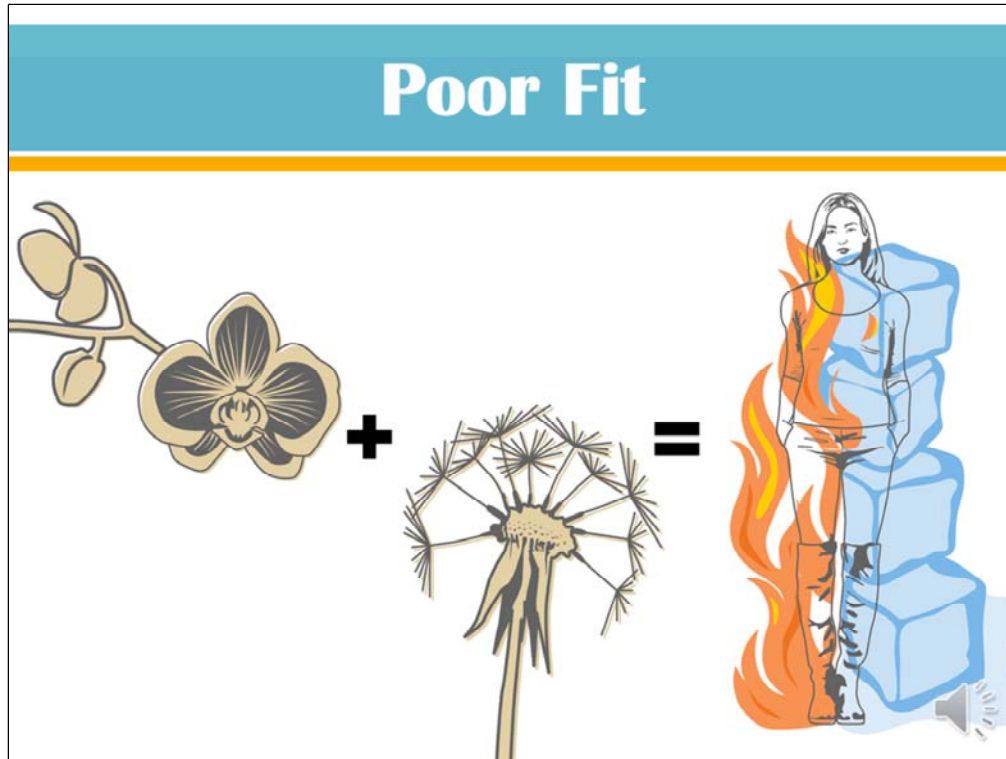


An invalidating environment is one in which communication of private experiences is met by erratic, inappropriate, and extreme responses. Emotions that are expressed can be punished or trivialized. It tells the individual that they are wrong for feeling the way they do, or that their interpretations are inaccurate.

Invalidation causes problems to go unrecognized and unsolved. The child is told to control her emotions without being taught how to do so. Life's problems are also oversimplified. These factors combine to cause the child to distrust and misunderstand their own emotional responses.

Extreme emotional reactions are often needed for the child to be attended to by caregivers. This creates a pattern of intense emotional expression in adulthood that is often misinterpreted as manipulation.

Types of Invalidating Environments can include: Chaotic Families, so called "Perfect Families", or Typical Families who emphasize cognitive control of emotions, focus on achievement and mastery as criteria of success, and de-emphasize the importance of emotional expression.

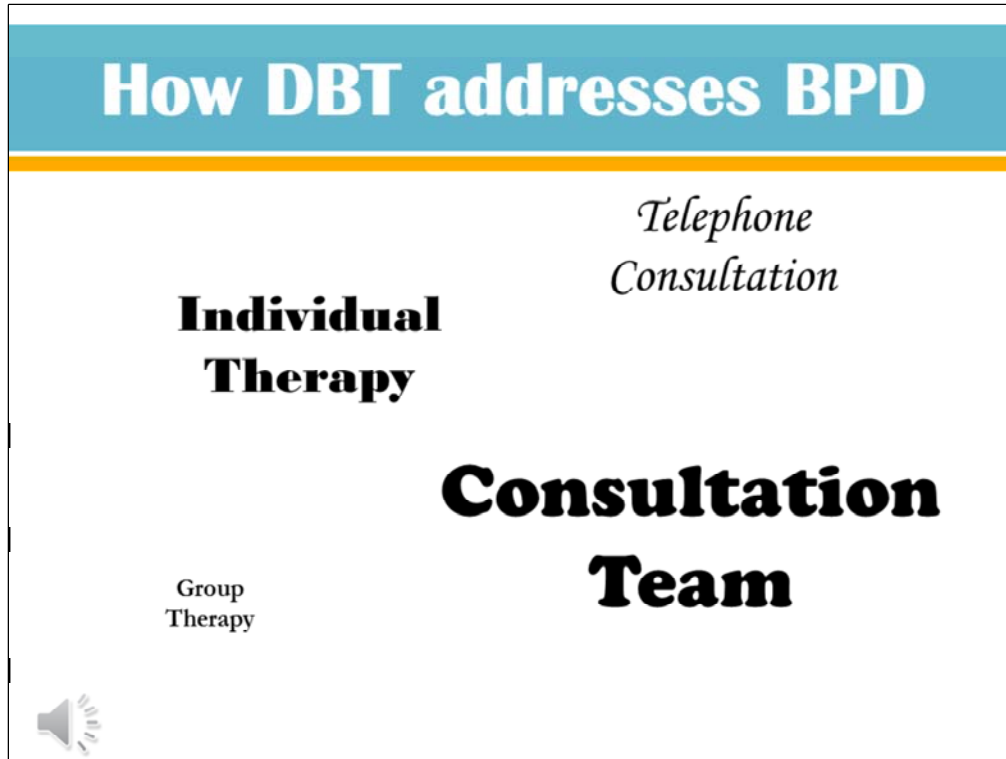


Again, remember that an invalidating environment does not necessarily mean that it was abusive. Sometimes a sensitive child is simply born to hardy parents, or alternatively a hardy child to sensitive parents.

To help explain the concept of poor fit to clients, we use this metaphor borrowed from one of Dr. Linehan's DBT training exercises. In it, the child is born as an orchid. It is very delicate and sensitive. It needs exactly the right temperature, amount of light, and moisture to thrive. But it is born to parents who are dandelions. The dandelions can grow anywhere, they thrive in a crack in the sidewalk. So the dandelion doesn't understand the orchid's needs. The dandelion says "ah, you don't need more light, I grew up in this shady corner and it was just fine for me. Buck up, you'll be alright. Stop being so sensitive, you're not cold, the temperature is just fine, your brother dandelion over here is growing like a weed." So the orchid grows up not trusting their own needs for nourishment, (which were definitely valid) while coming to believe that they are wrong for feeling the way they do and being the way they are.

An introverted child born to extroverted parents can be invalidating. (The child wants to color quietly while the parents prefer to go sky diving. The child gets the message that they are wrong for feeling anxious when overstimulated, they then begin to distrust their own instincts and emotional reactions.) Or an extroverted child who is born to introverted parents. (The child is loud and rambunctious while the parents just want a book and nice cup of tea. This child too gets the message that their natural propensity for energy and

action is wrong, that they should not be as excited or loud as they are. This too causes them to mistrust themselves. Their parents are so dissimilar to them that the parents simply do not know how to teach them how to deal with their internal states.) We use these metaphors with clients, or parents, in order to help reduce the blame and guilt regarding the invalidating environment. Parents were doing the best they could with what they had, unfortunately that wasn't all that the BPD child needed to learn to cope in the world.



So now that we've looked at what BPD is and an explanation for its' development, let's review how DBT organizes the symptoms and seeks to treat them.

DBT individual therapy is focused on enhancing client motivation and helping clients to apply the skills to specific challenges and events in their lives. In the standard DBT model, individual therapy takes place once a week for as long as the client is in therapy and runs concurrently with skills groups.

The therapist consultation team is intended to be therapy for the therapists and to support DBT providers in their work with people who often have severe, complex, difficult-to-treat disorders. The consultation team is designed to help therapists stay motivated and competent so they can provide the best treatment possible. Teams typically meet weekly and are composed of individual therapists and group leaders who share responsibility for each client's care.

Phone coaching is focused on providing clients with in-the-moment coaching on how to use skills to effectively cope with difficult situations that arise in their everyday lives. Clients can call their individual therapist between sessions to receive coaching at the times when they need help the most. Phone calls are important because clients may demonstrate the ability to act skillfully in session, but fail to transfer those skills into the real world.

DBT skills training group is focused on enhancing clients' capabilities by teaching them

behavioral skills. The group is run like a class where the group leader teaches the skills and assigns homework for clients to practice using the skills in their everyday lives. Groups meet on a weekly basis for approximately 2.5 hours and it takes 24 weeks to get through the full skills curriculum, which is often repeated to create a 1-year program. Briefer schedules that teach only a subset of the skills have also been developed for particular populations and settings.



Let's briefly look at some of the specifics of the Individual Therapy component of DBT.

Individual Therapy

DBT Diary Card

The space to put this week's

Date		Individual Therapy		Group Therapy		Medications		Rating Scale					
Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun
How many days did you fill out this card?													
<div style="display: flex; justify-content: space-between;"> 0 = 0 days 1 = 1 day 2 = 2 days 3 = 3 days 4 = 4 days 5 = 5 days 6 = 6 days 7 = 7 days </div>													

Hierarchy of Treatment Targets

1. Life-Threatening Behavior
2. Therapy Interfering Behavior
3. Quality of Life Interfering Behavior
4. Skills Acquisition

Non-Suicidal Self-Harm	Suicidal Thoughts		Suicidal Behaviors		Therapy Interference		Quality of Life Interference		Skills Acquisition	
	Thoughts	Behaviors	Thoughts	Behaviors	Thoughts	Behaviors	Thoughts	Behaviors	Thoughts	Behaviors
Yes	0-3	0-3	0-3	0-3	0-3	0-3	0-3	0-3	0-3	0-3
No	0-3	0-3	0-3	0-3	0-3	0-3	0-3	0-3	0-3	0-3
Yes	0-3	0-3	0-3	0-3	0-3	0-3	0-3	0-3	0-3	0-3
No	0-3	0-3	0-3	0-3	0-3	0-3	0-3	0-3	0-3	0-3
Yes	0-3	0-3	0-3	0-3	0-3	0-3	0-3	0-3	0-3	0-3
No	0-3	0-3	0-3	0-3	0-3	0-3	0-3	0-3	0-3	0-3
Yes	0-3	0-3	0-3	0-3	0-3	0-3	0-3	0-3	0-3	0-3
No	0-3	0-3	0-3	0-3	0-3	0-3	0-3	0-3	0-3	0-3

You can see here an example of a diary card. We have clients fill these out daily to track things like their moods, unhealthy behaviors, and healthy skills usage. They are an important aspect of keeping sessions on track and keeping clients in active participation of their own treatment.

How does DBT prioritize treatment targets?

Clients who receive DBT typically have multiple problems that require treatment. DBT uses a hierarchy of treatment targets to help the therapist determine the order in which problems should be addressed. The treatment targets in order of priority are:

1. **Life-threatening behaviors:** First and foremost, behaviors that could lead to the client's death are targeted, including all forms of suicidal and non-suicidal self-injury, suicidal ideation, suicide communications, and other behaviors engaged in for the purpose of causing bodily harm.
2. **Therapy-interfering behaviors:** This includes any behavior that interferes with the client receiving effective treatment. These behaviors can be on the part of the client and/or the therapist, such as coming late to sessions, cancelling appointments, and being non-collaborative in working towards treatment goals.
3. **Quality of life behaviors:** This category includes any other type of behavior that interferes with clients having a reasonable quality of life, such as mental disorders, relationship problems, and financial or housing crises.
4. **Skills acquisition:** This refers to the need for clients to learn new skillful behaviors to

replace ineffective behaviors and help them achieve their goals.

Within a session, presenting problems are addressed in the above order. For example, if the client is expressing a wish to commit suicide and reports recurrent binge eating, the therapist will target the suicidal behaviors first. The underlying assumption is that DBT will be ineffective if the client is dead or refuses to attend treatment sessions.

DBT individual therapy is focused on enhancing client motivation and helping clients to apply the skills to specific challenges and events in their lives. In the standard DBT model, individual therapy takes place once a week for as long as the client is in therapy and runs concurrently with skills groups.



It's impossible to explain DBT without talking about dialectics themselves. We'll explain the general concept and then look at specific areas where individuals with BPD have difficulty developing balanced lives. Each of these areas is called a Dialectical Dilemma and is considered a "secondary target" for treatment intervention.

2. Dialectics



Dialectics is a concept that can be difficult to explain. We like to use the analogy of a teeter-totter when discussing it with clients. The term dialectical means the fusion of opposites, so if black is on one side and white on the other, there is a middle ground of grey. This idea of the balance between extremes, of black and white, acceptance and change, hot and cold, walking the middle path, is carried throughout DBT (and this presentation.)

The primary dialectic within DBT, especially individual therapy, is change versus acceptance. Too much or too little of either leads to problems, both in the client's life and in the clinical hour. Push clients too hard to change, and they feel invalidated (they say you don't understand how miserable they are and how difficult it is to change). Rely too heavily on acceptance and again they feel invalidated (they say that you don't understand how miserable they are and how desperately they need to change) and then they panic.

As Steve mentioned earlier, this is the problem with relying too heavily on person centered therapy or conversely relying too heavily on cognitive behavioral therapy to treat BPD individuals.

Within the 4 skills modules that we'll discuss in a moment you'll notice both change strategies (like emotion regulation and interpersonal effectiveness) and acceptance skills (such as mindfulness and distress tolerance). Balance is key both in the clients' lives as well as in the therapist's stance.

Black & White Thinking

Reality is a gradation,
from dark grey to light grey.




There is little in reality that is unchanging and truth is never set in stone. Even our most highly regarded theories in science have been shown to be true but also false. For instance Newton's laws of motion are so accurate that we can precisely send a satellite to the far reaches of space, but those same laws completely break down at the smallest sizes of an atom.

In reality truth is always changing as we receive new information or find ourselves in new circumstances. The ability to modify our thinking and find new realities is key to interacting effectively in our world. To say it another way: Reality is neither dark nor light, it's grey.

Black & White Thinking

Individuals with BPD tend to separate situations into just two categories.



The word cloud contains the following adjectives: Scary, Mean, Friendly, Ugly, Avoid, Bad, Beautiful, Approach, Horrible, Awful, Negative, Safe, Terrible, Less, and Crazy.

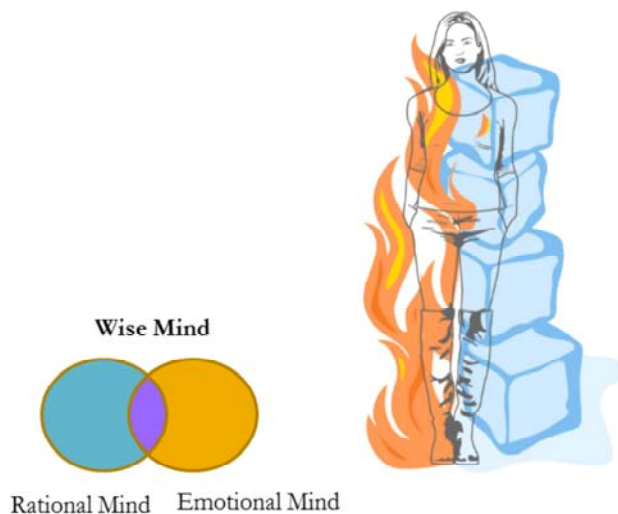
This need to unquestionably look to others for their sense of self can result in placing others around them initially on a pedestal; they may think that a person close to them can do no wrong. However, at the first sign of rejection the individual with BPD will quickly find fault with a person and see them as having no redeeming values or as untrustworthy and dangerous. As a result of black-and-white thinking, the individual with BPD will find themselves with a confused sense of identity and chaotic interpersonal relationships.

They did not create their problems but they are the only ones that can change them.
An abuser that was also a caregiver may have done horrible things to them but also been loving and kind.
You can want to give up and die and also have hope and keep pushing forward at the same time.

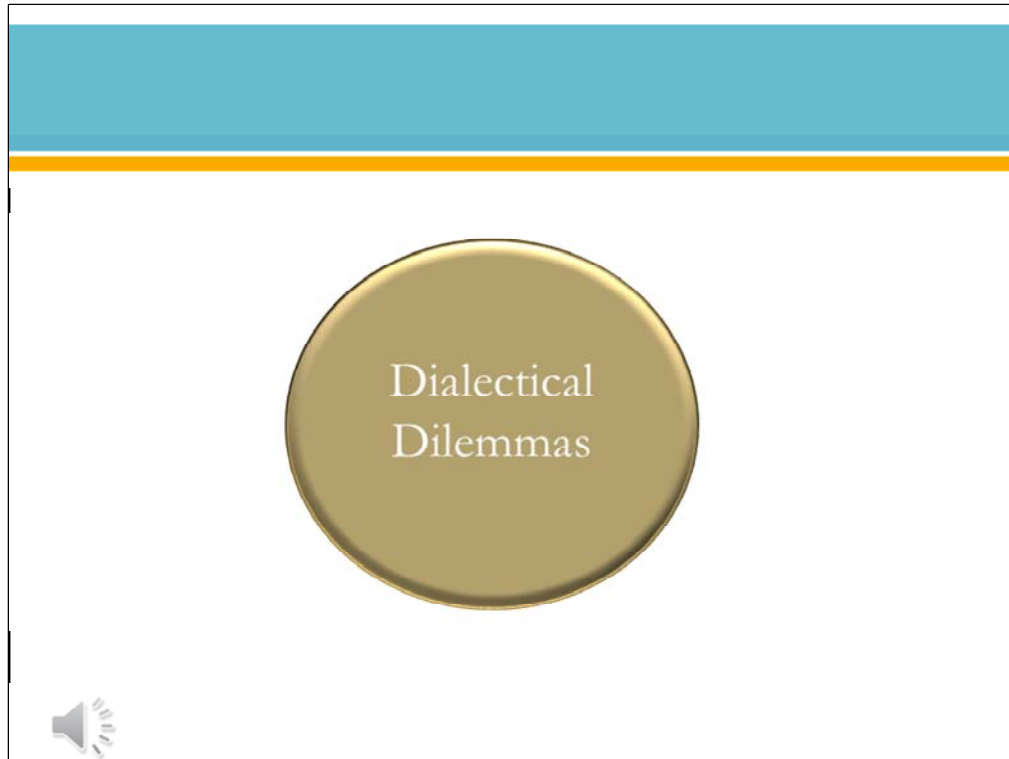


As we will see later on in the presentation, a difficulty in resolving conflicting information into a middle path can result in many ineffective strategies for coping with stress and result in extreme emotional responses and ways of interacting with others. At its core, DBT emphasizes finding a middle way, or to state it another way, DBT encourages synthesizing two opposing and contradictory views into a more effective way of seeing the world.

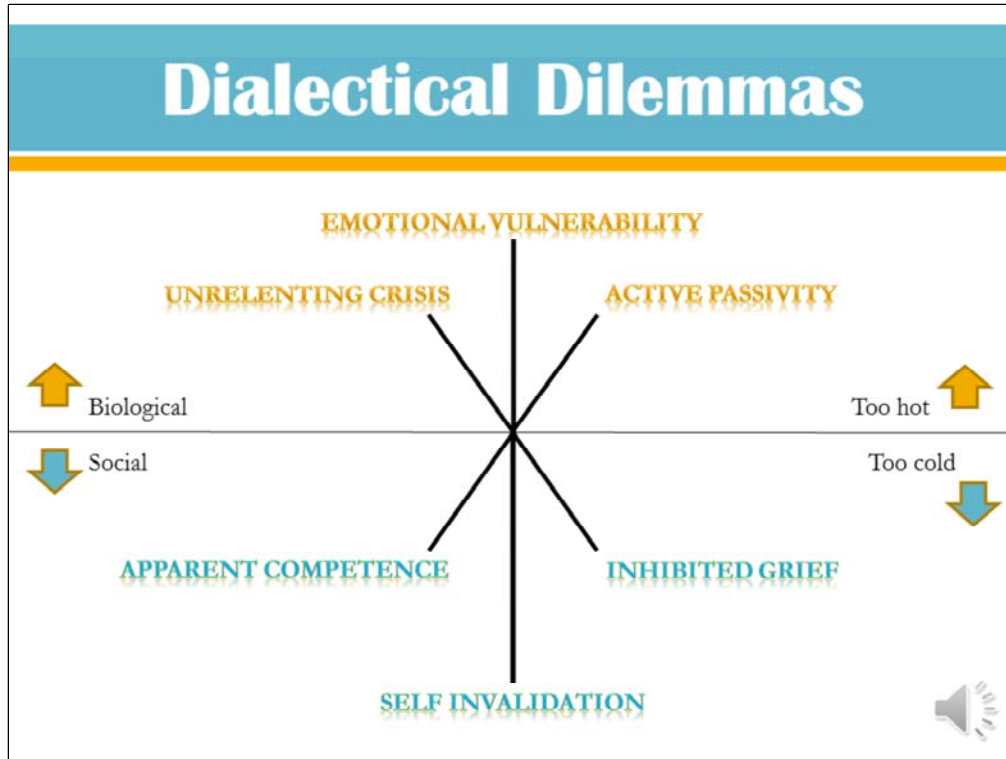
Hot & Cold



Throughout this presentation you may notice the orange, purple, and blue color scheme. We've used this to visually demonstrate the tendency for extremes within BPD clients and the use of balance within DBT. We'll go into more detail when we discuss the concept of Wise Mind within the Mindfulness Skill in a moment, but for now notice that extreme rationality (what DBT calls Rational Mind) can be shown in blue, while the opposite, extreme emotionality (or Emotional Mind) is shown in orange. The central piece of the diagram is the intersection of the two in purple – Wise Mind. So for our purposes in this presentation a nice balance in purple is always our goal: not too orange –which is hot, animalistic, and emotional but also not too blue- which is cold, robotic, and rational.



Individuals with Borderline Personality Disorder develop maladaptive strategies for regulating emotions. They will often under-inhibit their internal emotional experiences and its expression to others. In these instances the person with BPD is often viewed as out-of-control, incompetent and manipulative. It's as if the emotion is expressed unfiltered in its most raw biological or "animalistic" form. Conversely, they have often been told by others or experienced for themselves that unfettered emotion leads to conflict and crisis; they have therefore developed the converse strategy of over-inhibiting their emotions. They use every bit of energy at their disposal to shut down the internal experience of the emotion (to push away the feeling) and its expression. They have been taught that to show emotion is socially unacceptable and to put on a façade of control and competence. Both of these strategies often leave them without getting the help or changes in their environment that they so desperately need. When under-regulated, others do not take them seriously, call them dramatic and someone that is chaotic and to be avoided. When over-controlled their true suffering is not shown and others do not understand that help is needed. In some cases over-inhibition of emotion can lead to unresolved grief or appropriately processing of traumatic memories.



Moving from the general concept of dialectics, Dr. Linehan formulated these 3 Dialectical Dilemmas that help conceptualize the habitual polarizations that individuals with BPD often experience.

These are demonstrated through this graph and we'll go over each pair separately in more detail.

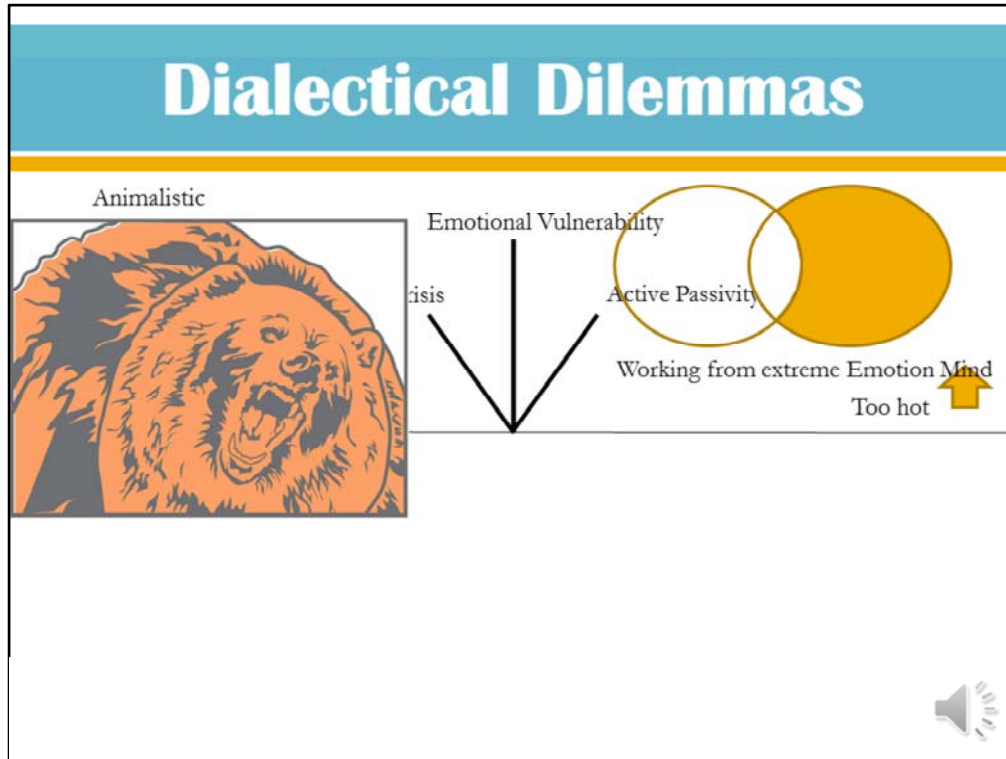
You can think of each of these lines as a teeter totter with an opposing concept on either side.

Notice that the top 3 are related to that orange, hot, emotional spectrum and are more biologically related. (BPD individuals were born hot-blooded.)

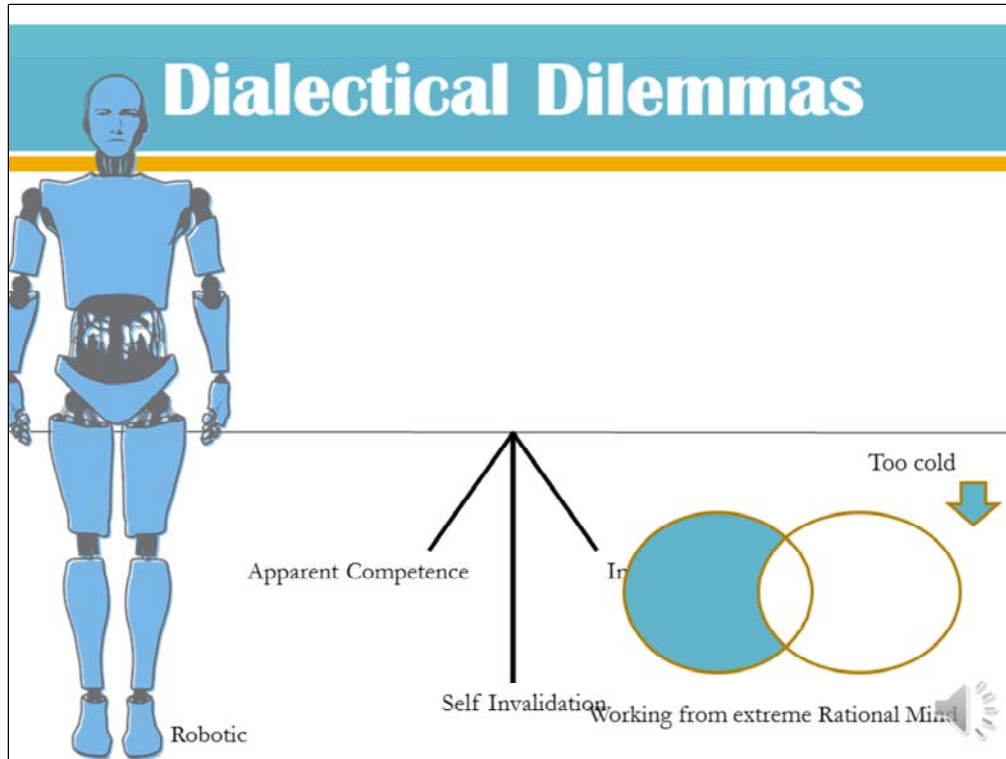
While the bottom three parts are the cold, shut down, and excessively rational reactions (or over reactions) to these emotional tendencies. These are more learned social traits that are a response to the environment. When BPD individuals were invalidated over and over again for their strong emotions they learned to regulate them by using these "skills". Unfortunately these methods tend to overcompensate and shut the emotions off completely. This results in a bounce back to the extreme emotions and the cycle perpetuates.

So in practice you'll notice a client vacillating between the two extremes on each dialectical dilemma. For instance they are born with Emotional Vulnerability (strong emotional

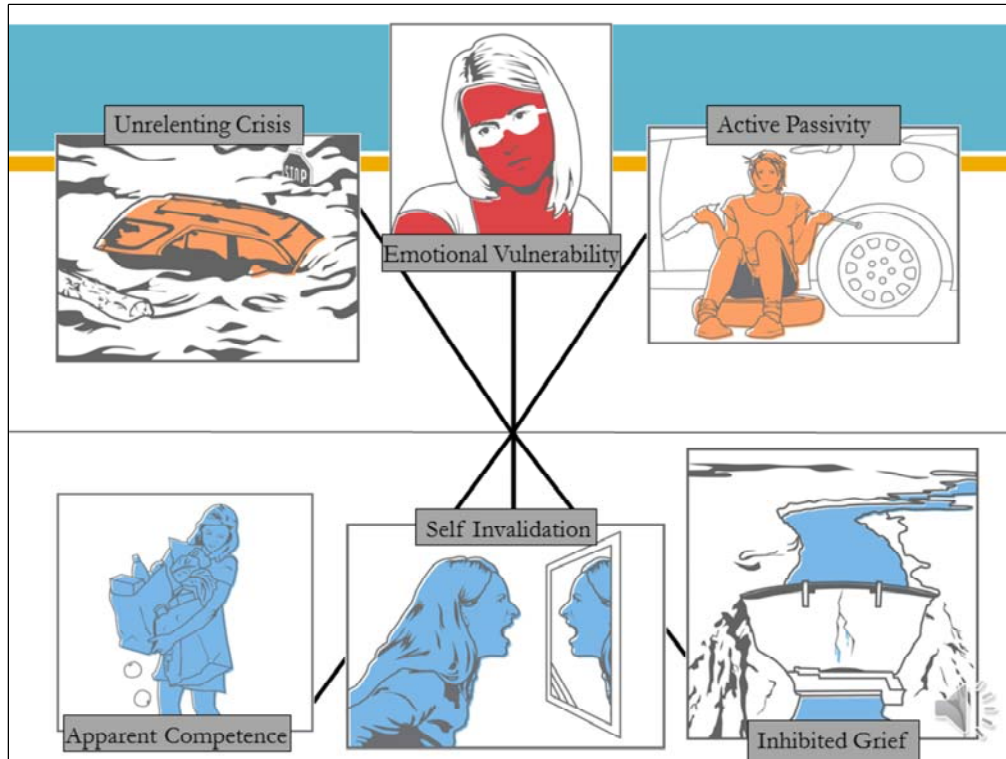
reactions) which they do not know how to regulate so they use the unhealthy skill of Self Invalidaion which works for a while to shut off the intense emotion, but inevitably sends them back to emotional vulnerability.



Visually we see here how these top three components are related to Emotion Mind and are biological or animalistic. We try to explain this to clients in a non-pejorative way with the analogy of a mad mama grizzly bear who is just running on instincts. We've found that putting a visual and metaphor on the concept has helped clients both understand and accept it. Once we have a common language the therapeutic process is much more easily facilitated.



On the other side of the balance beam, the aspects of Apparent Competence, Self Invalidation, and Inhibited Grief can be characterized as too cold, working from extreme Rational Mind, and being robotic. Again clients are able to talk about going into Robot mode when they shut off their emotions and invalidate themselves. Having a language through the metaphor can be very validating for the clients and makes the process smoother.



For the three Dialectical Dilemmas we have Unrelenting Crisis, paired with Inhibited Grief. Emotional Vulnerability with Self Invalidation. And Active Passivity with Apparent Competence.

Now we'll look at each pair of the dialectical dilemmas in detail.

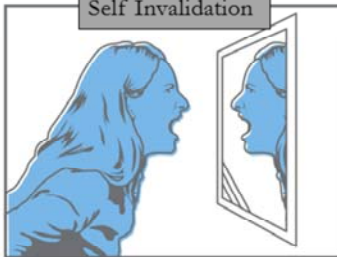
I personally explain these to my clients in individual therapy, again to validate their experiences, open up a dialogue, and to give us a common language that we can continually use in our work.

Dialectical Dilemmas

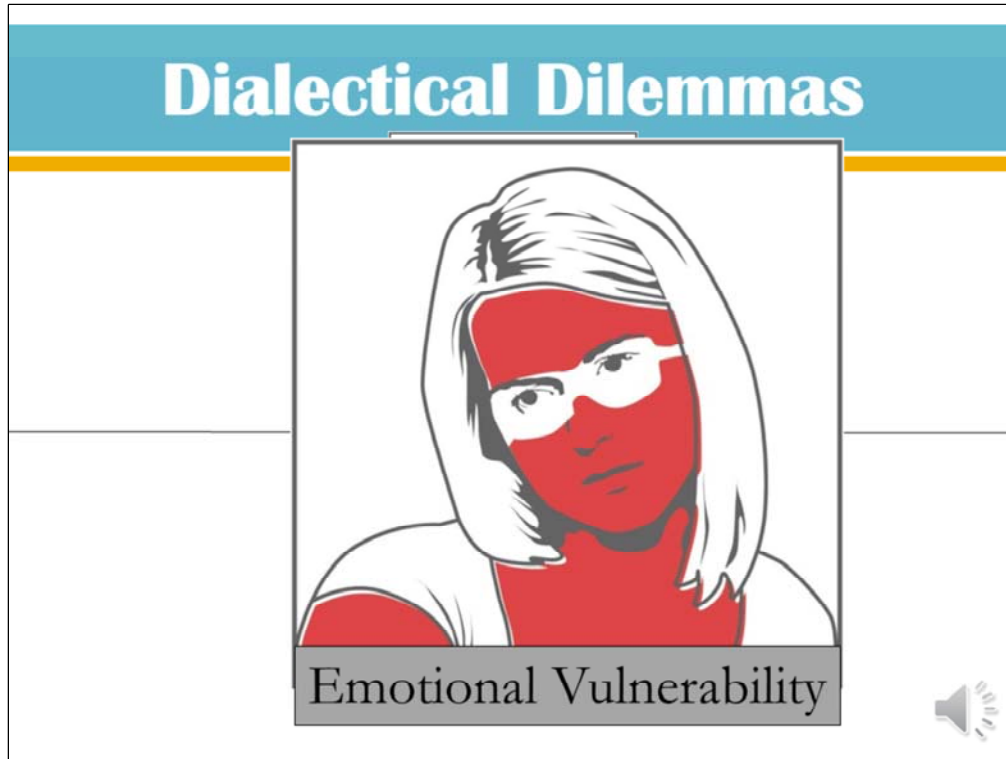


Emotional Vulnerability

Self Invalidation



We can start anywhere on the wheel, but let's first look at Emotional Vulnerability and Self Invalidation.



Emotional Vulnerability here is likened to the Emotional Burn Victim that you'll remember from the BioSocial Model. Individual's with BPD have a thin emotional skin; they are sensitive to stimuli (easily triggered), have a high emotional intensity (their highs are very high and lows are very low), and they take a long time to calm down. With poor skills to regulate this emotional reaction individuals can experience almost continuous intense pain. They're often desperate for anything that will decrease that pain.

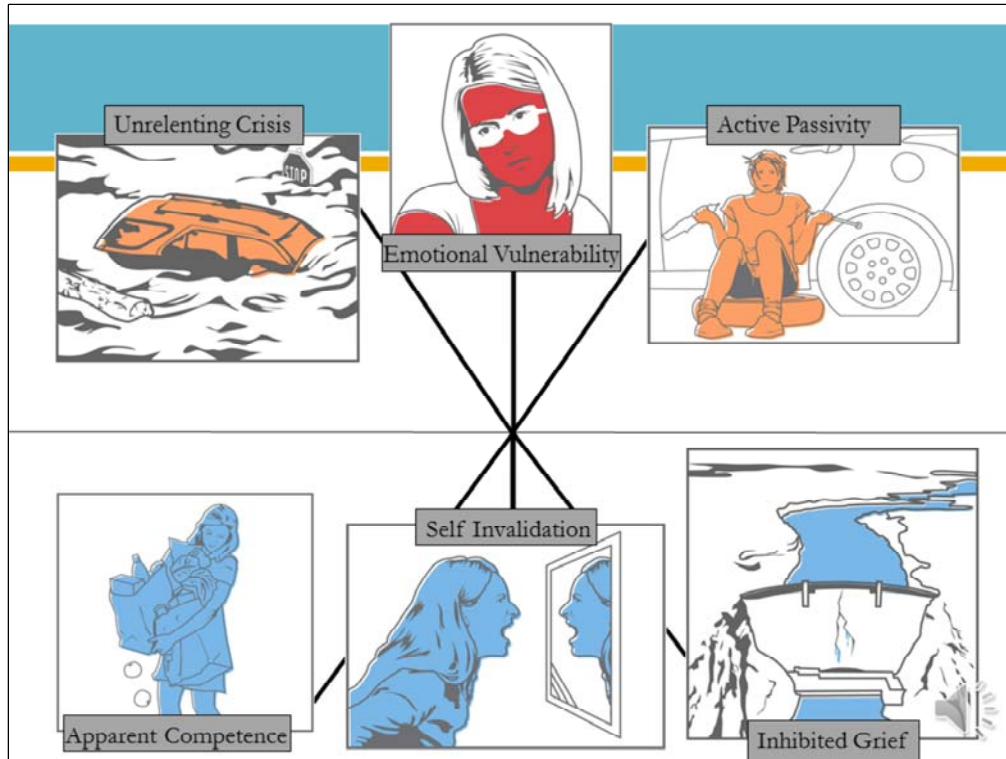
On this side of the dialectical dilemmas we can see what looks like an almost willful giving in to emotions. Due to a lack of skill, individuals can let their emotions flow freely and have full influence over their behavior. In this way you might see an individual saying 'if I feel sad then I must fully experience the sadness', or 'if I feel angry I have every right to completely act out that anger'. This often leads to even more emotional intensity and chaos. We've had clients in our program for example that have shown this through sobbing on the floor in the hallway or yelling and throwing their books into the trash. Inevitably guilt or shame will show up for the individual and they will flip over into self-invalidation.

Dialectical Dilemmas

Self Invalidation



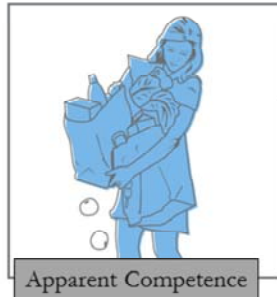
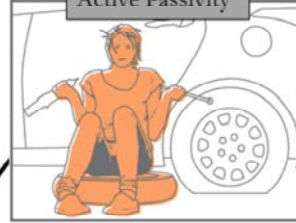
Individuals learn to react to their intense emotions and vulnerability by invalidating themselves, just like so many others have done throughout their lives. Self-blame and self-hatred come in and emotions are then harshly controlled or completely shut off. Sometimes one might see self injury as a means to quickly change those extreme emotions and to punish oneself for feeling emotional in the first place and not better controlling their behavior. Self Invalidation is also embodied by having unrealistically high standards and expectations of oneself or by maintaining a perfectionistic manner. It is a failure to recognize one's own natural emotional responses, thoughts, beliefs, or behaviors. Rather than acknowledging that their sadness might be too intense to be helpful, they tell themselves they should not be sad at all and then find a means to fully stop the sadness (impulsivity, self harm, denial, etc.). In the example of the individual crying in the hallway they might hit themselves and say how stupid they are in order to stop crying. Inevitably though their innate emotional sensitivity and lack of skills will throw them back to the other side.



So in our first dialectic we saw that the intense emotions that are unrestrained in emotional vulnerability lead to shame which involves self invalidation and a complete turning off of emotions and denying that they have any validity at all.

Dialectical Dilemmas

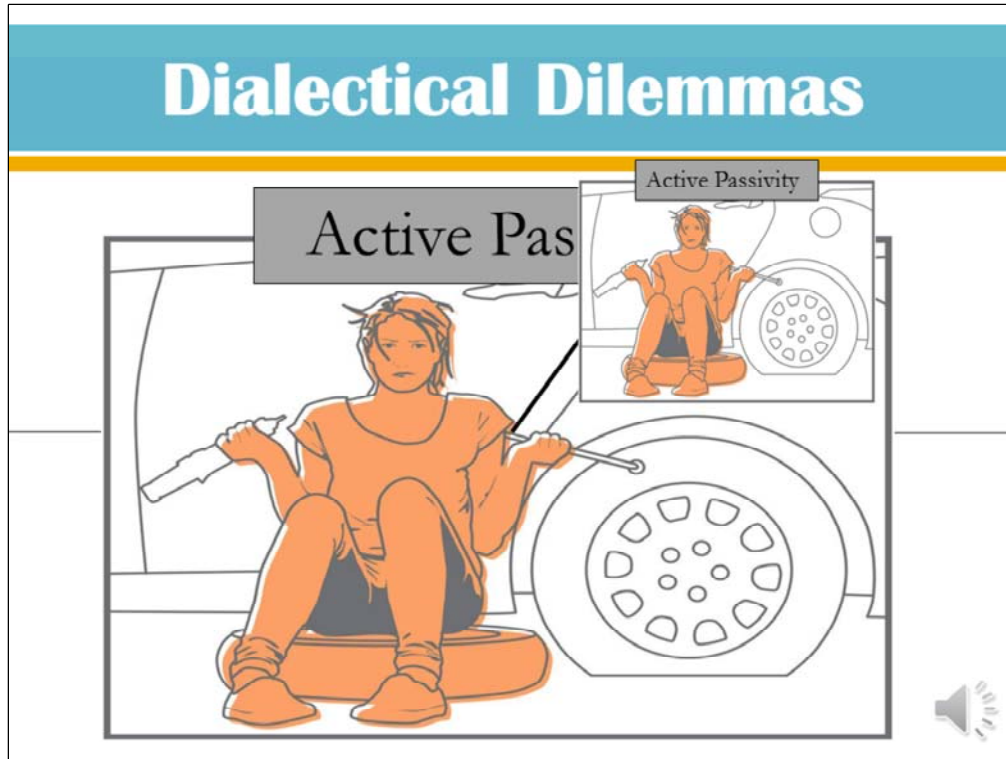
Active Passivity



Apparent Competence



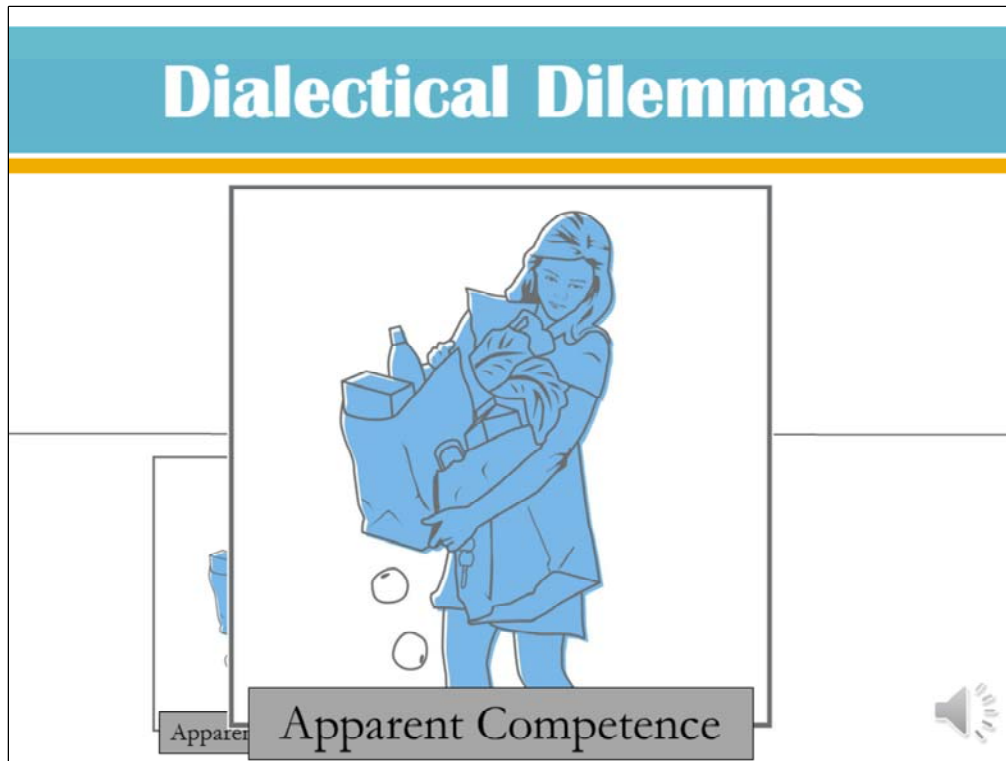
From here we'll move to our next dilemma, Active Passivity vs Apparent Competence. Another example of the too hot and under-controlled vs the too cold, and over controlled.



In this visual we're showing the interpersonal problem solving style of Active Passivity. This individual obviously has a problem with her flat tire, but rather than actively solving the problem or seeking assistance she looks very helpless and in need of rescuing.

In this dilemma individuals are in the extreme because they feel like that they have absolutely **no** ability to control their life, solve their problems, or make changes and they communicate this to others. Because they feel incapable of making changes they do not try to solve a problem (as in this flat tire example) but instead seek solutions from the environment. Unfortunately this solicitation is done in a passive and indirect manner. (This is a big source of burnout for therapists and of frustration for friends and family in a client's life. It is also where the label of "manipulation" is often applied.) Notice that clients are not consciously aware that they are getting their needs met indirectly. They have simply learned to distrust their own problem solving abilities, and due to their poor interpersonal communication skills they do not know how to directly and effectively communicate that they need more help. Other terms that relate to this concept are learned hopelessness and helplessness. Examples of active passivity might be suicidal gestures, making vague or indirect comments about distress, or sobbing uncontrollably on a voicemail but saying everything is fine. In all of these examples you can see that the individual is being active in seeking solutions from the environment, but is doing so indirectly, and is being passive about solving the problems themselves. Individuals might be seen as being 'coy' or 'playing games' when engaging these strategies which can easily elicit a response of either frustration or rescuing from the environment. Individuals can be seen as emotionally clingy

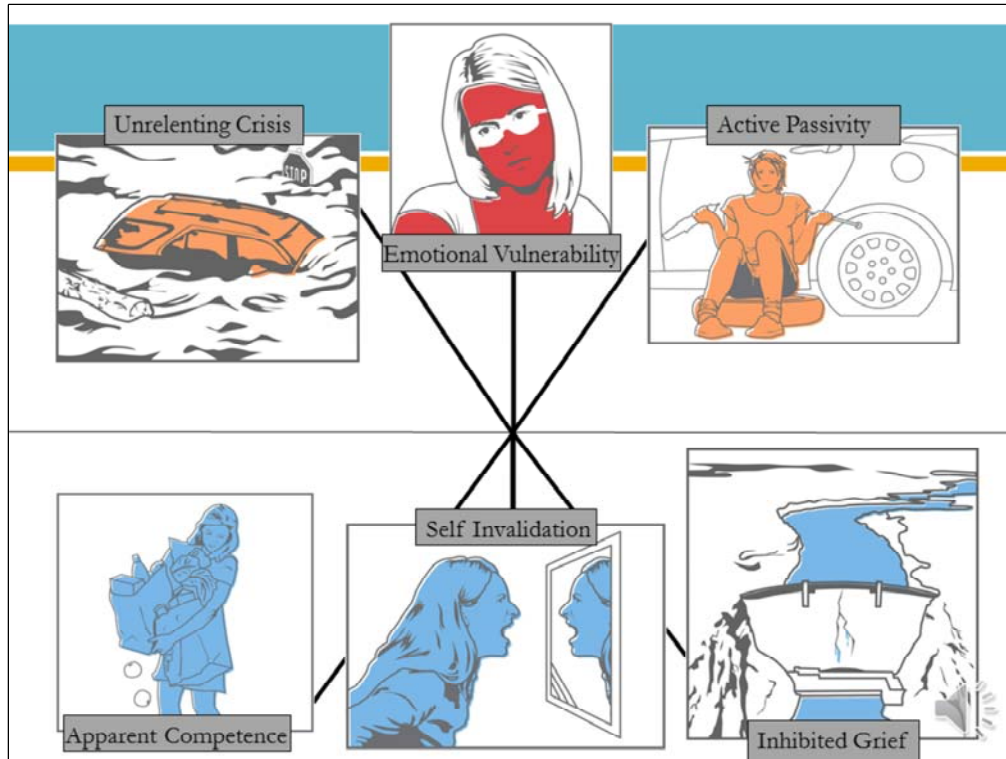
while having demanding behaviors. This is also related to the criteria of frantic attempts to avoid abandonment and intense emotional responses to the threat of loss of significant others.



On the opposite side of the scale, apparent competence is the tendency to **not** ask for help from the environment even when it **is** needed. Individuals can appear deceptively more competent than they actually are. This can happen when skills or competencies don't generalize in different situations, across moods, time, etc. Remember on this blue side of the teeter totter, individuals tend to over-control their emotions. It is again related to the shame of excessive emotionality or being unable to solve one's own problems. Once they flip to Apparent Competence they are likely hiding the nonverbal cues of emotional distress and are therefore not getting the response they need from their environment. (For example they may not receive any comfort from peers when they are sad due to a lack of tears and a stoic facial expression.) Also due to their habits of self invalidation they are likely not communicating the accurate degree of importance to situations or to their feelings. Others may not take them as seriously as they should be taken because they are under reporting the intensity of their emotions and needs. This would then cause a total lack of support, a decrease in functioning, and then a flip over to the hot side of active passivity to get needs met. (Again this can be seen as manipulation, "you were fine managing that difficult situation yesterday, how can you be so overwhelmed by this minor issue today?") In reality the individual's competence is unstable and extremely conditional.

This aspect of the dilemma might be seen in an individual who presents as fully capable in a high power job but is unable to pay her light bill when she gets home. Or someone who works efficiently in school but then becomes completely dysregulated if she experiences sadness. In session it might be an individual who appears completely calm and minimizes a

stressful situation but then self harms when she gets home.



From the dialectic of showing too much or too little confidence in one's own abilities, we'll move to the dialectic of over vs under control of emotional processing.

Dialectical Dilemmas

Unrelenting Crisis

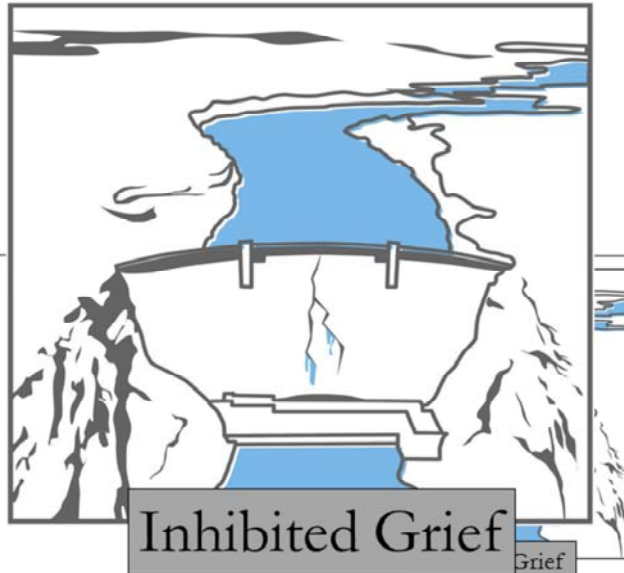


Inhibited Grief

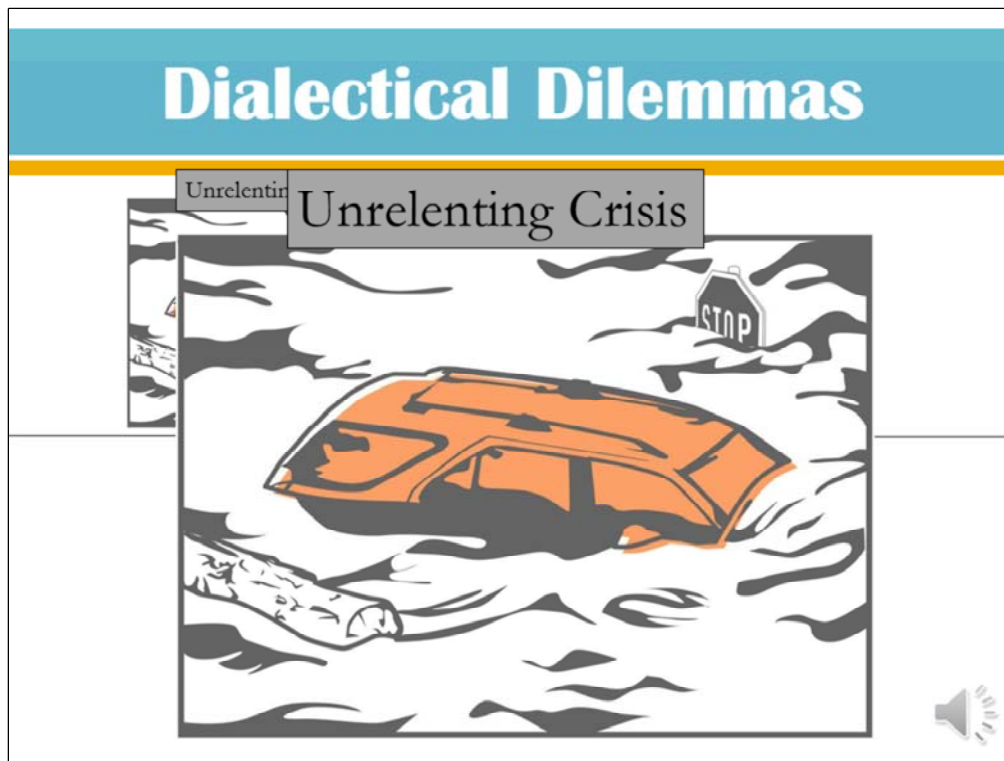


We've shown this dialectic visually through the metaphor of an overflowing dam of emotions that bursts and causes chaos and destruction in one's life.

Dialectical Dilemmas

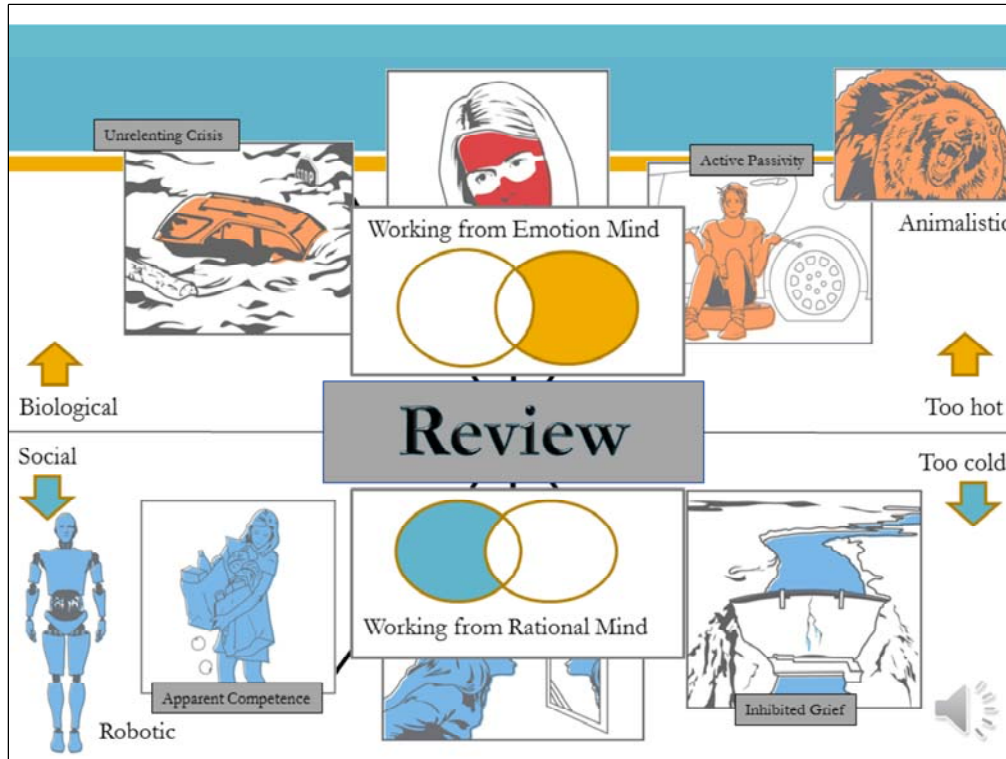


Inhibited Grieving is the tendency to avoid and over-control negative emotional responses to loss. It is involuntary and an automatic learned response to managing difficult emotions. Individuals stuff back painful emotions, especially those associated with grief and loss, sadness, anger, guilt or shame, anxiety, and panic. The many traumatic crises that occur in a BPD client's life cause much loss and grief. A series of these events can lead to bereavement overload. Without skills, individuals are unable to process the grief, continuing to stockpile it, which again leads to being overwhelmed and then more inevitable crises. In this way BPD is often likened to a specific form of PTSD. Some of the symptoms of BPD can be seen as means to avoid or control these emotions. For instance impulsively buying a car might be a way of avoiding sadness. That sadness is then never processed; after this habit plays out over the years there is a huge amount of unprocessed emotions backed up. This stress will inevitably cause the emotional dam to leak or burst and the pendulum will swing again to the other side; from over control to under control.



From the over control of inhibited grief we move to unrelenting crisis. This is often readily apparent in most BPD clients' lives and can be a major impediment during therapy. Therapists often feel like they are just putting out fire after fire. Remember this is addressed in DBT through the target hierarchy that specifies the structure and topics addressed in individual therapy sessions. The Unrelenting Crisis dialectic is a self-perpetuating pattern of frequent, stressful, negative events that occur more regularly and with more intensity than one would reasonably expect in life. It is often related to an individual's poor coping skills or intense uncontained emotionality. This can be likened to the dam of emotional over-control breaking and flooding the environment. The waters that flood wreak havoc in one's life. Before an individual can get up and recover from one crisis they are knocked down by the next wave of debris. In addition to an overflow of repressed emotions, unrelenting crises are often caused by an individual's attempts to avoid unpleasant emotions. In the example of buying a car to avoid sadness, one might see the crisis unfold when the rent can't be paid due to the new car note, this then dominoes into a fight with the husband, which leads to a relapse on alcohol, which causes more unpleasant emotions, which are then avoided, and the cycle progresses. The over-control of emotion leads to crisis after crisis through both the stress of unprocessed emotion and through the negative consequences of avoiding those emotions via poor coping skills.

The disabling nature of these crises for both the patient and the clinical hour underline the importance of both skills training and the target hierarchy in DBT.

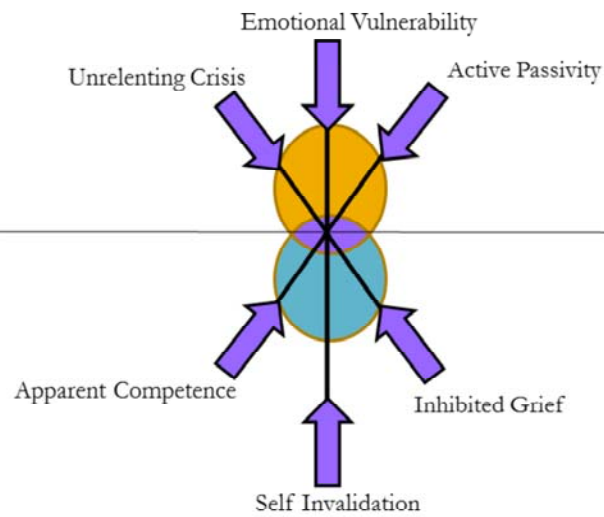




Emotional Vulnerability with its extreme uncontained emotions flips into punishment and self blame in Self Invalidation, never ending Unrelenting Crises are perpetuated by avoiding negative emotions and the buildup of unprocessed emotions in Inhibited Grief; and the tendency to solve problems in an indirect manner through Active Passivity is followed by completely denying the need for any assistance in Apparent Competence.

So now we've gone through all six of the dialectical dilemmas in DBT. The top portions are fueled by intense emotionality, while the bottom is maintained through shame. To review, remember these top images are working from extreme emotional mind, and the bottom are from extreme rational mind. The top is too hot, bottom too cold; top biological in nature, bottom social; and in our visual metaphors the top can be explained by an animalistic nature and the bottom robotic.

The more unhealthy an individual is, the more extreme they will be in all of these aspects and the more miserable there subjective experience is likely to be.

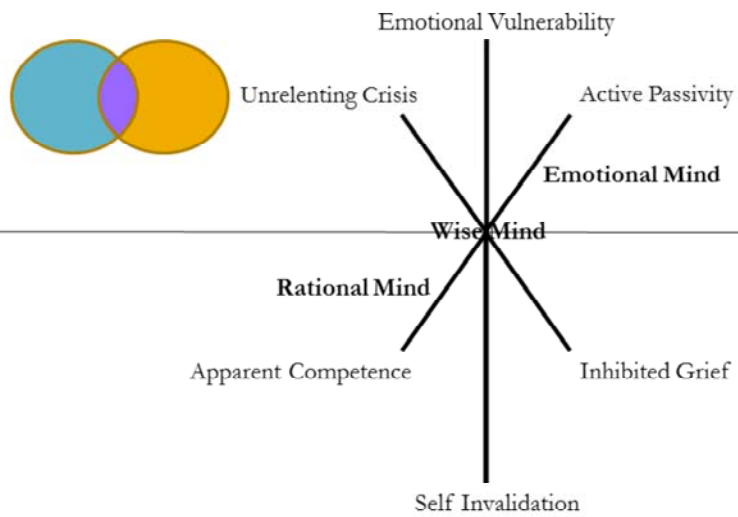
Dialectical Dilemmas




**Balancing
in
Wise Mind
is the goal** 

We all exist somewhere on the spectrum of these at any given point, but we want clients to come in towards the middle on each of these extremes.

Dialectical Dilemmas



Our goal, as always, is to walk the middle path through balance in wise mind.

End Part 1

- ☞ Thank you for watching Part 1 of this presentation!
- ☞ We've reviewed BPD, DBT,
Target Hierarchy, and Dialectical Dilemmas.
- ☞ Please continue to the next presentation:
Dialectical Behavior Therapy: A Visual Review: Part 2
which contains information on Skills Training and a Review.