Dialectical Behavior Therapy and the Treatment of Emotion Dysregulation

Shelley McMain and Lorne M. Korman
Centre for Addiction and Mental Health and the University of Toronto

Linda Dimeff
University of Washington and the Behavioral Technology Group

Borderline personality disorder (BPD) is a disorder characterized by severe disturbances in emotion regulation. In Dialectical Behavior Therapy (DBT), affect dysregulation is seen as a consequence of a transaction between a biological predisposition to emotion vulnerability and invalidating environmental experiences. In the past few years, a growing body of research has accumulated demonstrating the efficacy of DBT in treating severely disordered, chronically suicidal, and substance-dependent individuals with BPD. This article describes a DBT approach to the treatment of emotion regulation in individuals with BPD. © 2001 John Wiley & Sons, Inc. J Clin Psychol/In Session 57: 183–196, 2001.

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Dialectical Behavior Therapy (DBT) was specifically developed to address the unique needs of chronically suicidal individuals with borderline personality disorder (BPD; Linehan, 1993). A fundamental tenet of this approach is that problems with regulating affect are the core dysfunction in BPD. Symptoms reflecting the dysregulated emotional response system are the diagnostic criteria for BPD. Illustrative features of this dysregulation include affective lability, chronic feelings of emptiness, and intense and undercontrolled anger. In addition, pervasive negative emotions, perpetual emotional crisis, inhibition of

Correspondence and requests for reprints should be sent to: Dr. Shelley McMain, Centre for Addiction and Mental Health, 33 Russell Street, Toronto, Ontario, Canada M5S 2S1; e-mail: shelley_mcm-main@camh.net.

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emotional expression, affective numbing, and phobic responses to experiences of pain and loss characterize the emotional picture of individuals with BPD. The extreme problematic and impulsive behaviors which are common among this population (e.g., suicide, self-mutilation without intent to die, as well as substance abuse), are common sequela to strong, negative moods (Linehan, 1993).

This article examines a DBT approach to understanding and treating emotion dysregulation. We begin by presenting an overview of DBT followed by a focus on the theoretical foundations of DBT’s biosocial theory of emotion dysregulation. Next, different features of emotional dysregulation are considered, and the principles of DBT intervention are discussed. Considerable attention is devoted in the remainder of the article to an examination of the key DBT strategies that directly focus on elements of the dysregulated emotional system. Clinical issues and treatment strategies are clarified in the specifics of a case illustration.

Overview of DBT

DBT (Linehan, 1993) is a comprehensive treatment that blends cognitive–behavioral approaches with acceptance-based practices embodied by Zen and other contemplative practices. At the core of treatment is dialectical philosophy. Dialectics stresses the value of searching for and finding syntheses between natural tensions in order to bring about change. In DBT, the fundamental dialectic involves striking a balance between a therapeutic focus on change and acceptance strategies. In DBT, clients are encouraged, on the one hand, to acknowledge and accept emotional experience and, on the other, to push away and prevent negative emotions.

DBT is highly structured, particularly during the initial stage of treatment when the individual is lacking in behavioral control and consequently is engaging in dysfunctional and life-threatening behaviors. Standard DBT during this stage includes four basic modes of treatment, each offered concurrently and each serving a unique function. Weekly individual psychotherapy sessions focus on improving the client’s motivation to work toward obtaining a life worth living. DBT skills training groups, also provided weekly, emphasize skills acquisition and skills strengthening with the goal of enhancing the client’s capabilities. The focus of as-needed telephone consultation is to ensure generalization of skills and effective implementation of problem-solving strategies in daily living. A weekly consultation team meeting is held between DBT therapists for the purpose of enhancing each therapist’s own motivation and capability to effectively treat BPD clients.

In the past decade, several randomized control trials demonstrated DBT’s efficacy for severely disordered individuals with BPD. Koerner and Linehan (2000) provide a recent and thorough review of this research. The highlights of this review are briefly summarized as follows. In the initial DBT clinical outcome trial, DBT was compared to a treatment-as-usual (TAU) community control condition (Linehan, Armstrong, Suarez, Allmon, & Heard, 1991). DBT clients had fewer parasuicidal behaviors, less medically severe parasuicidal behavior, reduced hospitalization days, and better retention in treatment after one year of treatment compared to TAU clients. In a subsequent one-year follow-up study, DBT clients continued to engage in significantly fewer parasuicidal behaviors and had fewer psychiatric inpatient days compared to the TAU clients (Linehan, Heard, & Armstrong, 1993). DBT also was demonstrated as effective in reducing drug use and improving treatment retention in substance-dependent individuals with BPD (Linehan et al., 1999). Other pilot studies indicated that DBT may be effectively used to treat suicidal behavior in adolescents, binge eating, and disruptive behavior in forensic settings.
Theory of Emotions in DBT

The DBT biosocial theory of BPD views the disorder as primarily one of pervasive emotional dysregulation, a result of both high emotional vulnerability and deficits in the ability to regulate emotions (Linehan, 1993). Linehan sees most dysfunctional behaviors in individuals with BPD as either attempts by the individual to regulate intense affect or outcomes of emotional dysregulation. Thus, for example, individuals may deliberately cut themselves as a means to refocus attention away from emotionally salient stimuli and thereby reduce anguish; or they may lash out violently when feeling overwhelmed with rage.

Drawing from an extensive literature within and outside psychology, DBT views emotions as involving a full system response, and not merely the individual’s phenomenological experience of the emotion. Viewed in this light, emotions include biochemical changes in the brain, physiological changes (e.g., changes in heart rate, body temperature, muscle tone, and nerve signals), and action tendencies associated with the emotion (e.g., withdrawal with sadness, attack with anger, flight with fear). Action tendencies refer to a physiological and/or psychological preparedness to act in a particular way in order to establish, maintain, sever, or otherwise alter the individual’s relationship with its environment (Frijda, 1986). Expressive behaviors included in this emotion system include body language (e.g., facial and postural changes), and verbal communication of the emotion as well as other nonverbal communication behaviors (e.g., hitting, running away, hiding). The assumption with regard to these expressive behaviors is that they exist because they contribute to the survival of the organism. Bioevolutionary research suggests that there are a number of basic innate primary emotions, each with a characteristic facial expression and action tendency (Ekman & Friesen, 1975). Although this full system response may include cognitive interpretations associated with a specific prompting event that elicited the emotion, cognitions are not viewed as always being present.

Two additional assumptions of DBT (Linehan, 1993) are that emotions are prompted by events (either internal or external) and function to organize and motivate action. Emotions inform individuals about the personal significance of situations (Frijda, 1986). When functional, emotion can focus and direct attention to a particular environmental event while immediately and efficiently preparing the individual physiologically and psychologically for the event. Additionally, emotion provides individuals with information about their needs and tells them how they appraise themselves and their worlds (Lazarus, 1991). In this way, emotions also are self-validating in that they affirm one’s perceptions and interpretations of events. For example, the recognition of an actual environmental threat affirms the experience of “terror” and the emotion of fear. The accurate identification of an emotional response is critical to the regulation of emotions. Emotions also function to communicate information to others.

Theory of Pathologic Emotional Dysregulation and BPD

The etiology of emotion dysregulation in individuals with BPD is viewed as resulting from the transaction between biological anomalies and an invalidating environment (Linehan, 1993). These biological irregularities in BPD are believed to be caused by intrauterine and/or early childhood events, and/or by genetic factors. Initially, these biological irregularities are thought to result in emotional vulnerability, characterized by high sensitivity to emotional stimuli, emotional intensity, and by slow return to emotional baseline. Although the influence of biology in the etiology of BPD is not yet well-established, the last decade has seen increasing recognition that BPD and other personality disorders may be caused at least partially by temperamental irregularities in affect and impulse.
control. These differences may partly explain the affective instability, impulsive, self-destructive, and aggressive behaviors characteristic of BPD (Siever & Davis, 1991).

Linehan (1993) described the invalidating environment as one that trivializes, ignores, dismisses, and/or punishes the expression of internal experience by the child. An extreme example of an invalidating environment is one where the child has been sexually abused, then told that she is “making it up” when she speaks out about its occurrence (e.g., “Your uncle would never do such a thing!”). Indeed, studies have found childhood sexual abuse to be an important risk factor in the development of BPD (for a review, see Paris, 1995). However, less extreme environmental circumstances can contribute to serious emotion regulation problems in cases where the child is predisposed to heightened sensitivity. Consider a scenario where the child and his/her family are of different emotional temperaments—the child is highly emotionally sensitive and reactive in contrast to the other siblings and parents who are “laid back,” easygoing, and seldom reactive. One can easily imagine how, over time, the family could grow impatient and easily annoyed by the emotionally sensitive child’s intense emotional displays, choosing to ignore the behavior rather than give it attention. In response, the child’s behavior becomes more extreme and outrageous.

Linehan (1993) argued that an invalidating environment communicates to individuals that their descriptions and understandings of their experiences are fundamentally wrong (e.g., “There’s nothing to cry about! You’re making a big deal out of nothing.”) The child, therefore, is not taught to label internal experience or to regulate emotional arousal. In addition, these individuals do not learn to trust their own thoughts and feelings as accurate and legitimate responses to internal and environmental events. Rather, they are taught to invalidate their own perceptions and to scan the environment for cues about how to react. An invalidating environment also conveys to individuals that their experiences are due to socially unacceptable and undesirable character traits. Thus, for example, an individual is “bad” for feeling angry, “lazy” for not getting over loss quickly, or “weak” for feeling afraid. Because negative expressions of affect are not likely to be tolerated, the child’s expressions of needs are ignored or punished, and the child fails to learn effective strategies to manage his/her intense emotions. Quite commonly, individuals in the environment only attend to the more escalated displays of emotion, thereby inadvertently and intermittently reinforcing more extreme behaviors. Thus, the individual learns that extreme displays are necessary to achieve an environmental response. The combination of neglect or punishment of emotional expression and intermittent reinforcement of escalated, extreme displays teaches the child to oscillate between emotional inhibition and extreme emotional states. The inhibition of emotions also is likely to interfere with the development of the individual’s ability to sense expressive–motor responses (e.g., facial expression and body posture) associated with basic emotions and to accurately communicate these emotions to others.

An invalidating environment also oversimplifies the child’s problems. In essence, “stop complaining and just pull yourself up by your bootstraps” is the prevailing message conveyed to the individual expressing negative feelings. Emotionally vulnerable individuals thus simultaneously receive two compelling but conflicting messages about their internal experience. Because the ease of solving life’s problems is trivialized, the child does not learn to tolerate distress or to have realistic expectations and goals.

Changing Dysfunctional Behavior Patterns and Establishing Session Focus

A common problem faced by clinicians treating clients with BPD is the excessive number of dysfunctional behaviors in which these clients engage both in- and out-of-session. The
quantity and severity of these behaviors can make the prospect of treatment progress seem daunting. In DBT, primary behaviors to be changed (i.e., targets) are hierarchically arranged in recognition of the myriad of dysfunctional behaviors presented in each session by many clients with BPD. Behavioral targets are ordered as follows:

(a) decrease life-threatening behaviors (i.e., suicidal and parasuicidal behaviors);
(b) decrease therapy-interfering behaviors by client and therapist that compromise treatment effectiveness (e.g., nonattendance to treatment, arriving to session in an intoxicated state, arriving late or leaving early, falling asleep during session);
(c) decrease quality-of-life interfering behaviors (e.g., substance abuse, bulimia, homelessness, unemployment); and (d) increase coping skills. The logic for this hierarchy is simple: keeping these clients alive and engaged in treatment are necessary prerequisites to building a life worth living.

Determining the focus of a specific individual therapy session begins with assessing the presence or absence of the target behaviors in the preceding week. This task can be efficiently accomplished by reviewing the client’s DBT diary card, which tracks all relevant behaviors during the past week. A moment-by-moment analysis of internal and external events that precede and follow each targeted behavior is performed (e.g., “All right, now how is it that you cut yourself last week? What exactly happened?”). Discovering the variables associated with the dysfunctional behavior is an integral part of determining which adaptive behaviors need to be integrated into the client’s repertoire. Given the plethora of dysfunctional within-session behaviors exhibited by many clients with BPD, how does the therapist decide which to address? The principle is to attend to and treat those within-session behaviors that are functionally related to the out-of-session dysfunctional behaviors. For example, for clients with chronic anger problems, rageful reactions to neutral prompts in therapy may provide an excellent in-session opportunity to assess and treat difficulties such as hypersensitivity.

Many of the within-session dysfunctional behaviors fall under the rubric of DBT secondary behavioral targets. In contrast to primary behaviors that are specific, discrete, and easily monitored by clients, secondary behavioral patterns are subtle and complex. These typically interfere with progress in treating the primary behaviors (Linehan, 1993). Because they are usually tied to primary behaviors, the therapeutic task becomes one of treating secondary behaviors in conjunction with treating the primary behavioral targets. Thus, for example, in fostering a client’s capacity to manage and tolerate the intense hurt that precedes suicidal gestures, the therapist also more generally is working to decrease the client’s emotional vulnerability.

The two core secondary behavioral patterns include emotion vulnerability and self-invalidiation. Emotion vulnerability refers to the client’s experience of extreme vulnerability and reactivity to the environment. Like burn victims, individuals with BPD often function as if the slightest movement will result in unendurable pain and loss of all behavioral control. It is as if people with this behavioral pattern are phobic of all cues associated with their negative emotions. Clients prone to this secondary target will often attempt to avoid these emotional cues by withdrawing, escaping, or attacking. Many in-session therapy-interfering behaviors (e.g., dissociating during session, verbally attacking the therapist) are maintained by this pattern of avoidance to negative emotional cues. Self-invalidation is best understood as the individual’s adoption of characteristics from the invalidating environment (Linehan, 1993). Three common patterns include (a) the inhibition of emotional experiences or expression (e.g., discomfort with anger can result in silence and a rigid facial expression), (b) perceiving oneself as fatally flawed (e.g., self-hate, self-disgust, shame about self, undeserving of kindness and respect), and (c) oversimplifying the ease of solving current problems. The tendency to oversimplify the ease
of tackling life’s problems is illustrated in the example of another client who, after cutting herself, judges unrealistically that by simple force of will she will never cut again and therefore has no interest in engaging in problem-solving activities to realistically prevent a recurrence in the future.

Other secondary targets associated with emotion vulnerability and self-invalidation that need to be changed include unrelenting crises, inhibited grieving, active passivity, and apparent competence. *Unrelenting crises* refers to the seemingly endless number of crises individuals with BPD always seem to be facing (e.g., loss of a job one week, eviction the next week, children removed from the home the following week, and so on). The frequency with which these crises occur leads some clinicians to blame their clients for generating the myriad of crises, when in fact they frequently result from poor judgment, a common consequence of emotion dysregulation. *Inhibited grieving* involves the inability to integrate extremely painful reactions related to trauma and loss. This results in a repetitive pattern of avoiding stimuli associated with loss. *Active passivity* refers to a pattern of approaching problems passively and helplessly, and often includes efforts (particularly when emotionally dysregulated) to mobilize the environment (including the therapist) to problem-solve on his or her behalf. Finally, *apparent competence* is characterized by a state of incongruence between verbal and nonverbal expression and emotional experience. The client fails to accurately communicate his or her emotional experience to others in the environment. For example, a client may participate in a confident manner throughout a group therapy session, showing little of her intense anxiety and shame. Failing to communicate her distress or ask for help, her intense affect, unacknowledged, may serve as a precursor to self-mutilation or substance use.

**Intervention Framework in Treating Emotions**

As noted earlier, treatment strategies in DBT are dialectically balanced between change and acceptance/validation. All DBT treatment strategies directly or indirectly aim to enhance emotion regulation. These diverse strategies focus on elements of the emotion regulation system, including cognitions, phenomenological experience, expressive–motor behavior, and action tendencies. In DBT, the enhancement of emotion regulation is guided by three basic principles. First, the enhancement of emotion regulation involves an ability to be aware of and accept emotional experience. In DBT, strategies related to this principle include validation, mindfulness, and emotion regulation skills. Somewhat paradoxical to this first notion, the other two principles emphasize changing emotions (Linehan, 1993). The second principle involves the ability to regulate emotions by shifting attention away from cues or stimuli associated with problematic affective responses and acting in a manner opposite to strong negative affect. In DBT, this includes the development of skills to tolerate distress such as emotional containment (i.e., self-soothing). It also involves strategies to change the expressive components of emotions such as breathing, relaxation, and engaging in behaviors that are opposite to the negative affect (e.g., approaching rather than avoiding in response to fear). Third, emotion modulation involves changing negative affect through new learning experiences. In DBT, exposure procedures are used to unlearn problematic reactions by developing new associations to negative affect.

**Change Procedures**

*Exposure.* Behavioral exposure-based procedures are used in DBT to treat dysfunctional responses to negative emotions. Three components of exposure are applied: (a) *cue*
exposure: exposing the individual to cues associated with negative emotions. For example, a therapist continues to pursue a detailed behavioral analysis of a substance-use episode with a client who reacts with intense shame in response to any scrutiny of problematic behaviors; (b) response prevention: blocking or preventing the dysfunctional response, such as escape or avoidance of emotional experience; and (c) opposite action: facilitating the client to act in a manner opposite to the emotion’s action tendency, such as deep, slow breathing to generate physiological relaxation as an opposite response to autonomic nervous system activation.

The following vignette is offered to illustrate the principles of exposure that were outlined previously. A formal exposure procedure was introduced with one of our clients who was preoccupied by the idea that there was something defective about her appearance. Through assessment and case formulation, we recognized the pattern between instances of looking directly at her body (cue, through a mirror) followed by extreme self-loathing and self-disgust, followed by a cocaine binge (dysfunctional behavior). After explaining the exposure procedure, the client was instructed during the session to look at an area of her body in a mirror that generated a moderately high level of distress. The client’s subjective level of distress was assessed at the beginning and throughout the process of the exposure intervention to ensure the levels decreased with continued exposure to the cue. Each attempt by the client to stop the procedure by sitting down, closing her eyes, or arguing was blocked as the therapist assisted the client in generating opposite actions to self-loathing thoughts and the experience of shame. Unable to generate a behavioral response opposite to self-loathing, the therapist encouraged the client to practice deep breathing to relax her body while attending to aspects of her body that she liked. Over the course of treatment, the client was eventually able to scan her entire body without becoming emotionally overwhelmed and using drugs.

Skills Training. The teaching of skills to reduce vulnerability to emotions and facilitate emotion regulation is also an important strategy. Reducing emotional distress requires the ability to observe one’s responses to events. Mindfulness skills teach clients to non-judgmentally observe and bring one’s full attention to current experience. According to Linehan (1993), increasing mindfulness of current emotional experience functions as an informal exposure to negative emotions, which over time helps to extinguish maladaptive avoidance responses.

Linehan (1993) describes a number of specific skills that are critical to the enhancement of emotion regulation. Emotion regulation skills teach individuals to understand emotions by learning to accurately observe, describe, and label emotions. It is important to help clients learn to identify the stimuli, situations, or other factors that precede and follow problematic emotional responses. For example, in cases of chronic anger, clients are educated about the common dysfunctional interpretations of others’ behaviors that often precipitate such anger and about the withdrawal by others that typically follows. Clients also are taught to reduce emotion vulnerability by decreasing factors that contribute to emotional distress, such as developing proper eating and sleeping habits, exercising, abstaining from substance use, and by increasing pleasurable activities. The ability to cope with painful affect is integral to emotion regulation and is a common deficit contributing to impulsive behavior. Distress tolerance skills emphasize learning to accept and cope with intense negative emotions. In this regard, the development of strategies to cope with distress, such as distracting, self-soothing, and breathing exercises, also are emphasized.

In DBT, changing emotional experience also involves helping clients act differently from how they feel (Linehan, 1993). This strategy follows from emotion theories that
hold that changes in the motoric–expressive components of emotions, such as changing
facial expressions and body language, bring about changes to the full emotion response
system. For example, the action tendency associated with fear is to pull away and avoid,
and thus approaching the feared object often decreases fear. To illustrate using another
example, increasing one’s activity level in response to depression can have the effect of
decreasing depression. The practice of skills outside of sessions is regarded as essential in
consolidating change.

Acceptance Strategies

Validation. A common problem for therapists working with clients who experience
intense emotional distress and life-threatening behavior is the tendency to disregard the
importance of validation strategies. Therapists, fueled by anxiety brought on by working
with people who are desperate, often overemphasize the role of change strategies (Line-
han, 1993). The problem with overemphasizing change with clients suffering from BPD
is that it tends to recapitulate aspects of the early invalidating environment.

In DBT, validation strategies are used to help clients understand that their responses
make sense. The therapist communicates validation by listening, reflecting, and high-
lighting the valid or “kernel of truth” in the client’s phenomenal experience. Validation
strategies in DBT are viewed as necessary but not sufficient. According to Linehan (1997),
validation in the absence of a focus on problem solving is invalidating. If a client lacks
necessary skills, it is important that therapists recognize this and help clients enhance
their capabilities. Nevertheless, DBT seeks to strike a balance between validating expe-
rience and encouraging change. Thus, as one of the two core therapeutic strategies, val-
idation is not considered merely the backdrop to the “real work” of therapy, but rather a
necessary intervention fostering self-validation (Linehan, 1993).

Emotional validation provides a unique set of strategies to counter the tendency of
individuals with BPD to vacillate between the inhibition of emotional expression and
intense emotional reactions. The emphasis in emotional validation strategies follows directly
from the notion that emotion provides adaptive information. According to DBT theory,
dysfunctional emotional and behavioral responses are connected to valid responses to
events. Finding and amplifying these primary responses constitute the essence of emo-
tional validation (Linehan, 1993).

Because individuals with BPD typically inhibit their emotions, they may have diffi-
culties identifying personal reactions to events. They may withdraw from intense emo-
tion and reveal few observable facial or postural expressions of emotion. When this
happens, it is very difficult both for the individual and for others to identify the individu-
al’s emotional response. Because there may be little awareness of the emotional experi-
ences that precede impulsive behaviors, the individual is likely to feel out of control. For
healthy functioning, clients need to learn to notice and describe their current emotional
state (Greenberg & Safran, 1987). With clients who are prone to inhibiting emotions, the
task is to amplify their emotions by helping them observe and describe their reactions.
Initially, the therapist actively attempts to read clients’ emotions and may offer a list of
possible descriptors in a multiple-choice question. Later on in therapy, therapists would
employ more open-ended questions in order to allow clients to generate descriptors of
their feelings.

Case Illustration

Excessive anger is a problem for many individuals with BPD. In the following case,
chronically hostile affect and out-of-control behaviors were dominant responses and fre-
quent foci of therapy. The client’s anger caused major interpersonal conflicts that resulted in social isolation and contributed to impulsive actions and persistent depression and shame. At other times, she inhibited her anger, which was associated with chronic avoidance of conflict and the premature termination of interpersonal relationships. This case illustrates the therapeutic method of pushing for change while emphasizing acceptance of the client.

**Presenting Problem/Client Description**

The client is a 32-year-old woman (Jane) who was diagnosed with concurrent borderline personality and substance-use disorders. Her difficulties included a history of suicide attempts, persistent suicidal ideation, and self-harm behaviors, including the mutilation of her body. In addition, she had a lengthy history of polysubstance abuse including heroin, marijuana, and benzodiazepines. Jane referred herself to our hospital for treatment and was initiated on methadone maintenance treatment. In addition, she agreed to attend one year of treatment in our outpatient DBT program for individuals with BPD, which includes the standard treatment modes (e.g., individual therapy, skills group, telephone consultation, therapist consultation group). Early into treatment, her behavior was characterized by repeated verbal altercations with staff and other clients. These episodes were characterized by flying into rages, throwing things, and slamming doors. This behavior was usually in response to Jane feeling that her needs for support were not being met.

In terms of her social and family history, Jane had repeated experiences of being physically and sexually abused by significant others over the course of her life. She was removed from her home at a young age by child welfare authorities. This contributed to her sense of self-doubt, feelings of being neglected, and her belief that there was something wrong with her. Jane often felt scared and angry about the way she was treated in her life and felt unable to protect herself from others, whom she constantly perceived as offending and violating. She lived in perpetual emotional crisis and feared being attacked and perceived by others as bad and unacceptable.

**Case Formulation**

As a result of the invalidating experiences of recurrent physical, sexual, and emotional abuse, Jane learned that her personal feelings, thoughts, and behaviors were wrong, bad, and inappropriate. She failed to learn to acknowledge and trust her own experience, and instead learned to attribute negative judgments to her personal reactions. She felt confused and ashamed of her feelings, particularly anger and sadness. Now, even the slightest experiences of invalidation by others are felt as extremely painful. The inhibition of her primary emotional experiences, such as adaptive anger and sadness, leave Jane unable to derive the benefit of the important adaptive motivational information associated with these primary emotional responses. This likely contributes to her pattern of staying in abusive relationships and her failure to address self-protective needs. The suppression of primary emotions, including the muting of her facial expression, made it difficult for others, including her therapist, to know what she was feeling.

Another consequence of Jane’s learning history was that she behaved as if the only way to evoke a reaction from others was through extreme responses or emotional escalations such as anger or suicidal threats. Drawing from the work of Greenberg and Safran (1987) to understand Jane’s excessive anger, it can be viewed as a conditioned secondary reaction or “learned” emotion that blocks more primary or “authentic” emotional responses
to her experiences of abuse such as sadness, fear, and anger. Jane’s pattern of interpersonal engagement was characterized by attack.

Course of Treatment

The primary goal of treatment was to help this woman get her behavior under control. This included helping her reduce life-threatening behaviors, such as suicidal threats and self-harm, and behaviors that interfered with her receiving treatment, such as repeated failure to show up for appointments, lateness for appointments, occasional intoxicated presentation in sessions, and a tendency to fall asleep or dissociate in sessions. Other treatment targets included serious behaviors that compromised her quality of life, such as substance use and angry outbursts. In this therapy, emotional vulnerability and self-invalidation were linked to excessive anger and failure to engage in treatment. Flexibility in blending acceptance and confrontation to change were needed. The therapist alternated between validation and pushing the client toward change by offering critical feedback to the client (e.g., highlighting that her anger is problematic), a cue that was associated with problematic shame. At the same time, the therapist improved Jane’s capacities to change by teaching her skills to tolerate painful feelings.

The following transcribed segments reflect excerpts from several of Jane’s treatment sessions. In each segment, the dilemma for the client is discussed as well as the challenge this behavior posed for the therapist in terms of intervention. The therapeutic goals are described along with the strategies employed to facilitate change.

The following segment occurred approximately three months into treatment and illustrates the exploration of failure to complete her self-monitoring diary cards (i.e., therapy-interfering behavior). Over the course of therapy, the client repeatedly failed to complete diary cards. Through repeated analyses of this behavior, it was revealed that her decision to not complete the diary card was associated with intense shame elicited by thinking about her problem behaviors and becoming highly self-critical. As a result, engaging in self-monitoring was a highly aversive experience because it exposed her to the stimuli that triggered shame. Hence, her failure to complete the monitoring task was an avoidance behavior that served to help her escape from feelings of shame.

CLIENT: (raised voice, very angry tone) I hate to say it, but I don’t feel like doing my diary cards every day. The last thing I want to do is this stupid card. When I wake up, it’s the last thing on my mind.

THERAPIST: Okay, we need to talk about that because . . . in fact if you’re saying that “hey, this part of the treatment isn’t for me,” . . .

CLIENT: Yeah, I don’t feel like it’s for me. I don’t want to wake up every day, and go “Oh, I used! I don’t want to remind myself of that. Oh I felt like suicide last Tuesday, April the 17th! Oh my god, I was sad last week!” Why do I want to keep remembering? I don’t want to keep remembering!

THERAPIST: Oh, okay, so you want one of those therapies that you don’t remember things?

CLIENT: No, I just don’t want to keep bringing it up all the time. “Oh, I was raped on so-and-so date, let me remember what I felt at the time.”

THERAPIST: It’s so painful for you to think about these experiences. (pause) Look, of course you could choose not to talk about that stuff since it feels so distressing to talk about it. . . .

CLIENT: Sometimes it’s so upsetting. Because sometimes I could come in an okay mood and then leave depressed. I end up leaving here so upset.

THERAPIST: No, I agree, that doesn’t sound too comfortable.
CLIENT: It's like my mother in the past, reminding me of all my faults all the time.

THERAPIST: Yeah, it’s so painful to bring up this stuff. Why would anyone want that?

CLIENT: Yeah, exactly!

THERAPIST: Now here’s the dilemma. We could not talk about your problems, and if this would take away your pain and misery, I’d be all for it. On the other hand, if we help you figure out how to tolerate your bad feelings, then you won’t have to rely on your pain medicine or resort to thinking of killing yourself when these feelings come up.

In the preceding segment, the therapist focuses on the client’s failure to complete her self-monitoring homework and addresses the secondary targets of emotion vulnerability and emotional inhibition. The therapeutic goal was to increase the client’s ability to tolerate her experience of shame triggered by the task of self-monitoring behaviors. The therapist actively validates the client’s pain to help her make sense of her failure to engage in the therapeutic task. In addition, the therapist helped her label her emotional response, an important aspect of emotion regulation. A warm communication style and use of validation was balanced with a focus on change-oriented strategies. At times, the therapist’s communication style was intentionally unorthodox in an effort to move towards change. Irreverent communication, an offbeat style, was used to try and shift the client from her more extreme affective response. The therapist also used the strategy of playing the devil’s advocate to help the client gain a sense of control and to help her see a different point of view.

The next segment is from a later session which followed a situation in which the client was demoted a level in her methadone carry status after repeated urine screens that tested positive for opiates and benzodiazepines. In this session, the client vacillated between feelings of anger toward her physician and hopelessness about her ability to effect changes in her life. Her intense anger led her to miss several sessions and consider dropping out of treatment. The client was overwhelmed by a sense that her core self had been fundamentally attacked as a result of the critical feedback from her physician. She vacillated between judging her physician and herself as wrong. The dilemma was that if her physician was right then she felt nothing she had achieved so far was of any value. On the other hand, if she was right, then it confirmed for her that she is doomed to attacks and criticism in her life.

CLIENT: So my methadone physician says “you’ve got dirty urine because we found a trace of Tylenol.” I don’t want her anymore as my doctor. I’m tired of her. I feel that she is on some kind of high somewhere when it comes to me, and I guess that really bothers me too that she’s trying to tell me that my life is going to be this way or that way, and I’m 32 years old, and she’s younger than me, and she’s trying to tell me how my life should be. Later in my life I’m going to be an old woman, and if I want to take a Tylemol, I’ll take one.

THERAPIST: It sounds like you feel so incredibly controlled, and not respected.

CLIENT: Well, when you’ve been coming to a program, and you’ve been doing your darndest to stay clean... I get a headache one day, and I take a Tylenol 3 with codeine, not two, not three, just one—I didn’t go take 10 or 15.

THERAPIST: That’s great. Excellent that you only took one, and that you didn’t take 10 or 15.

CLIENT: Well, I never did that!

THERAPIST: Well, at one time you were. How did you end up on methadone? Of course you did! You ended up on methadone because you were taking...
Therapist: Right, exactly! Heroin is way stronger than Tylenol. And you have done so well in finding other ways to cope with your pain.

Client: (crying) Well, she’s wrong! I want her to stop doing this to me. She’s making me feel like not coming in for treatment anymore. She makes me feel like an awful person. She’s ten years younger than me, and she’s punishing me!

Therapist: You feel put down by her, and this makes you feel like giving up completely on treatment? Like not even coming in for therapy anymore?

Client: Yes.

Therapist: So help me figure out the links here. You have a problem in your relationship with Dr. A—she tells you that you have Tylenol in your urine and cuts your carries privileges—and how do you get from there to wanting to give up on any treatment for yourself?

Client: It just does. Because she’s making things too difficult for me. I don’t know. I just don’t give a shit about coming here. I figure after three fucking years of trying the best I can do and not doing drugs and talking about it and joining a group and now just for doing codeine and valium or whatever, I’m being screwed. Big deal! Do you know why I do it? Because I have panic attacks! Because I start shaking. I don’t abuse it. Maybe it stays in my system so long because I’m so fucking fat!

Therapist: Your feeling so put down by her makes you feel like giving up on yourself, makes you feel like everything you’ve done has not been worthy or has not been an accomplishment.

Client: Maybe.

Therapist: Because that’s what I hear. Because let’s say Dr. A doesn’t give you any credit. That then you tell yourself there’s nothing at all that you’ve done that’s valuable? Does that fit?

Client: Maybe. I just hate coming here now. Yeah.

Therapist: It sounds like, one of the things is, you have been so criticized when you were younger. You were just criticized and attacked all the time. And you never got the support that you needed, and somehow now it is so hard for you to get critical feedback from somebody. So when Dr. A says, “I’m taking away your carries,” it just hurts so much. Somehow the piece we have to figure out is how to help you develop a thicker skin so you keep track of what’s important to you regardless of what feedback you get from other people, regardless of what other people say and do. Because, if we can help you stay focused on your long-term goals even in the midst of critical feedback, that would be an incredible strength. Because you’re definitely going to face more criticism in your life.

In the preceding segment, the dilemma for the therapist is that a focus on changing the client’s behavior is experienced by the client as invalidating. At the same time, an overemphasis on therapeutic warmth and validation may leave the client feeling that there is no escape from her misery. In this segment, the therapist seeks to validate the client’s efforts to change, the difficulty in making change, and the pain stemming from believing that others are critical of her efforts. At the same time, the therapist pushes the client to do more. The therapist uses praise to support her reduction of substance use and balances this by confronting the client about her continued substance use. The therapist offers her own insight into the client’s behavior in an effort to help the client notice patterns in her behavior. The therapist also focuses on finding solutions to problematic behaviors such as challenges to her dysfunctional belief that others are constantly critical of her behavior. The therapist works to help the client refrain from acting impulsively by encouraging her to act in a manner that is consistent with her personal goals.
Outcome and Prognosis

After one-and-a-half years in treatment, Jane no longer exhibits the same pattern of perpetual emotional crises that initially brought her to our DBT treatment program. She has not engaged in self-harm behaviors in almost a year and has reduced her substance use from a daily pattern of abuse to less than ten occasions over the past year. Her manner of expressing herself is less explosive. Her angry outbursts have been significantly reduced, as evidenced by her ability to engage in the clinic appropriately. For example, at the outset of treatment, she was frequently involved in verbal altercations with treatment staff, friends, and strangers on the street. Though she still often comes to sessions irritated and angry, she rarely reports outbursts with others. She has developed better skill in communicating with others and is more direct and effective in pursuing her needs in relationships.

Validation seems to be critical to her self-acceptance and her ability to assert her needs with others. Jane’s sensitivity to perceived criticism from others, and tendency to react quickly with anger to protect her from feelings of shame, is a behavioral pattern that has been openly discussed in treatment. Jane now is more able to consider alternative and less negative interpretations of others’ behaviors. Notwithstanding these changes, she continues to be sensitive to criticism and often responds with anger in her relationships. Although Jane has improved relations with people and has begun to effectively relate to others, treatment continues to focus on decreasing her emotional vulnerability and increasing self-validation and emotional experiencing.

Conclusions

A fundamental premise of the DBT approach is that problems in regulating affect constitute the core dysfunction in BPD. Thus, DBT strategies are oriented toward addressing emotion dysregulation. DBT interventions focus on the various elements of the emotion response system, including emotions, cognitions, expressive–motor behavior, and action tendencies. The primary goal in the first stage of DBT is to treat out-of-control behaviors that threaten the individual’s life, treatment, and quality of life, and more generally to help achieve balance in behaviors and emotional experiencing. However, a number of secondary, complex patterns of behavior interfere with progress on the primary treatment targets and therefore are often foci of treatment. Core secondary behavioral patterns include emotional vulnerability and self-invalidation. DBT therapists utilize a number of specific techniques to directly enhance emotion regulation. These include exposure-based procedures, emotional validation, and the enhancement of capacities such as paying attention to experience, shifting attention away from cues associated with negative emotion and learning to observe, describe, and understand the function of emotions.

Select References/Recommended Readings


