Creating borderline personality disorder can seem like a no-win situation. If we try traditional cognitive-behavioral therapy (CBT) and emphasize change, patients feel unheard and invalidated; they may withdraw, quit, or even attack. But if we suggest ways to accept unhappy situations, they may feel we don’t understand their suffering.

A more effective approach is dialectical behavior therapy (DBT), first developed to treat highly suicidal persons with borderline personality disorder and used with other populations that have difficulty regulating their emotions.

This article describes how invalidating environments may damage emotional health and suggests how psychiatrists can use DBT’s methods when treating borderline personality disorder.

**BIOLOGY PLUS ENVIRONMENT**

For the patient, borderline personality disorder’s behavior clusters (Table 1):

- function to regulate emotions
- or result from emotion dysregulation

DBT theory identifies emotion dysregulation...
Three characteris-
ics—high sensitivity, high reactivity, and slow return to baseline emotional state—
tify high emotional vulnerability.
H High sensitivity. The person reacts more quickly and to more things than do others in emo-
tion-provoking situations. When walk-
ing, for example, they may pass someone who doesn’t say hello. Most people would 
shrug this off, but persons with high emo-
tional sensitivity may quickly notice, assume 
there is a problem, feel they have done some-
thing wrong, then feel shame and anger.
High reactivity. Their emotional reactions are large, and the high arousal dysregulates 
cognitive processing.
Slow return to baseline. Events stack up 
because emotional reactions are long-last-
ig for persons with high emotional vulner-
ability. They don’t have time to get over one 
thing before something else happens.

Table 1

<table>
<thead>
<tr>
<th>Diagnostic criteria for borderline personality disorder</th>
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<tr>
<td>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, as indicated by five (or more) of the following:</td>
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<tr>
<td>1. Frantic efforts to avoid real or imagined abandonment.</td>
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<td>2. A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation</td>
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<tr>
<td>3. Identity disturbance: markedly and persistently unstable self-image or sense of self</td>
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<td>4. Impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating)</td>
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<td>5. Recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior</td>
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<td>6. Affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and rarely more than a few days)</td>
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<td>7. Chronic feelings of emptiness</td>
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<td>8. Inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights)</td>
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<tr>
<td>9. Transient, stress-related paranoid ideation or severe dissociative symptoms</td>
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as the primary deficit in borderline personality disorder. Biologically based emotional vulnerabil-
ity is seen as interacting with an inability to mod-
ulate emotions because of a skills deficit.

Emotional vulnerability. Three characteris-
ics—high sensitivity, high reactivity, and slow return to baseline emotional state—
tify high emotional vulnerability.

Table 2

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<tr>
<th>Table 2</th>
<th>Strategies used in dialectical behavioral therapy</th>
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<tr>
<td>Structural strategies</td>
<td>Organization of sessions, attending to the treatment hierarchy, reviewing progress, checking on other modes of therapy</td>
</tr>
<tr>
<td>Problem assessment strategies</td>
<td>Defining problems with specificity, conducting chain analyses, developing and testing hypotheses</td>
</tr>
<tr>
<td>Problem solving strategies</td>
<td>Providing didactic information, generating and evaluating solutions, teaching skills and coaching on use of skills, generalizing skills to the real-world environment</td>
</tr>
<tr>
<td>Contingency management</td>
<td>Use of reinforcement, extinction, aversive contingencies, and principles of shaping</td>
</tr>
<tr>
<td>Exposure-based procedures</td>
<td>Both formal and informal</td>
</tr>
<tr>
<td>Cognitive strategies</td>
<td>Contingency clarification, observation and description of cognitions, cognitive modification</td>
</tr>
<tr>
<td>Validation strategies</td>
<td>Appearing interested, accurately reflecting, correctly articulating things that have not been fully expressed, explaining behavior in terms of learning history or biological factors, acknowledging the validity of responses in terms of current events, interacting in a manner that is radically genuine, communicating believing in the patient</td>
</tr>
<tr>
<td>Reciprocal communication strategies</td>
<td>Being responsive, expressing warm engagement, being nonjudgmental, using self-disclosure, maintaining a reasonable power equilibrium</td>
</tr>
<tr>
<td>Irreverent strategies</td>
<td>Engaging in a matter-of-fact manner, directly confronting dysfunctional behavior, using unexpected, irreverent or humorous responses</td>
</tr>
<tr>
<td>Dialectical strategies</td>
<td>Using a balanced style, balancing acceptance-oriented strategies with change-oriented strategies, magnifying tension, using metaphor, modeling dialectical thinking and behaviors, moving with speed and flow</td>
</tr>
<tr>
<td>Case-management strategies</td>
<td>Following a model of consultation to the patient when long-term outcomes are more important than short-term outcome; intervening in the patient’s environment when short-term outcome is more important than long-term outcome</td>
</tr>
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</table>

questions herself and searches the social environ-
ment for cues about how to respond to similar sit-
uations in the future.

Robbie, age 4, completes a drawing and shows it to his father with delight. His father points out some “sloppy” coloring. If his father repeatedly finds fault with his work, Robbie is likely to not show him his work or stop drawing, and his expres-
Balanced therapy for ‘borderline’ patients

Specific to borderline personality disorder is that the environment ignores genuine emotional expression, and the individual’s emotions escalate. This pattern is reinforced when the listener finally rewards emotionally extreme behavior with attention or desired changes. As the pattern is repeated over time, extreme emotional reactions become the norm rather than the exception, and the emotional chaos can make the person wish to die. Acting on that desire when past expressions of desperation have been ignored or invalidated can provide attention or interventions that would never happen after simple emotional expressions.

Thus, an environment that does not recognize or validate genuine emotional expression can reinforce suicidality.

Table 3: Modes of therapy in outpatient DBT

<table>
<thead>
<tr>
<th>Function</th>
<th>Mode</th>
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<tbody>
<tr>
<td>To improve motivational factors</td>
<td>Individual psychotherapy</td>
</tr>
<tr>
<td>Enhance capabilities</td>
<td>Skills training</td>
</tr>
<tr>
<td>Assure generalization to natural environment</td>
<td>Between-session consultation</td>
</tr>
<tr>
<td>Enhance therapist capabilities and motivation to treat effectively</td>
<td>Therapist consultation team</td>
</tr>
<tr>
<td>Structure the environment</td>
<td>Consultation to the patient</td>
</tr>
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</table>

DBT: dialectical behavioral therapy

These three invalidating patterns cause persons to search the social environment for cues about how to respond to situations. They may question themselves, their identity, and the appropriateness of any emotional expression. As a result, they may oscillate between emotional inhibition and extreme emotional styles, set unrealistic goals and expectations for themselves, and eventually despair of being able to solve their problems.

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Solving no-win therapy

Pitfalls with emphasizing change. Therapy that emphasizes solving problems and getting things to change typically triggers high arousal in persons with borderline personality disorder. Feeling out of control, they respond by trying to get in control, including attempts to control the therapist.
Similarly, they see attempts to get them to change their behavior as invalidating their experiences or, worse, who they are. Intense emotions aroused by the message they hear—that they are the source of their problems—impair learning and intensify their efforts to gain control. In a battle for control, collaboration and therapy cannot occur.

Case example. Ms. K wants you to understand how difficult her life is because of difficulties with her boss. You start talking about what Ms. K can do to change the situation, without acknowledging how difficult it is to deal with her boss.

Ms. K feels upset and says you don’t understand. For her, the interaction has led to emotion dysregulation and impaired cognitive processing.

Pitfalls with emphasizing acceptance. Most persons who come to therapy very distressed want something in their lives to change. If your primary message is acceptance instead of change, they may lose confidence in you.

Case example. Ms. K wants help dealing with her boss, who is making life quite difficult. As her therapist, you respond with warmth and acceptance but offer no suggestions as to how she might change the situation. Ms. K likes the way you listen to her but abandons therapy after several sessions.

At first, patients with borderline personality disorder may like the warmth of client-centered acceptance approaches. Over time, however, they may feel their therapy sessions are out of control. They may think the therapist doesn’t understand the situation, doesn’t know how to help, or that situations that are troubling them cannot be changed.

Balanced therapy. DBT solves the change-or-acceptance dilemma by attempting to help patients with borderline personality disorder change themselves and their lives while offering strategies for accepting themselves and their situations. DBT includes problem-solving and acceptance strategies (Table 2).

DBT’S 4 THERAPY STAGES

DBT is a comprehensive treatment. The original outpatient model for borderline personality disorder (Table 3) has been adapted to different settings and applied to other populations.

Outpatients meet weekly in individual psychotherapy and a skills training group. Therapists also meet weekly in a consultation team viewed as “therapy for the therapist.”

Between sessions, therapists consult with patients by telephone to:
- decrease suicide crisis behaviors
- increase generalization of behavioral skills
- decrease patients’ feelings of conflict, alienation, or distance with the therapist.

Four stages. DBT follows four stages. For persons with borderline personality disorder, researchers have evaluated the efficacy of stage-1 therapy. Studies on stage-3 DBT have been conducted with nonborderline-personality individuals with eating disorders. The goals at each stage are:

Stage 1. Move from severe behavioral dyscontrol to behavioral control. Decrease suicidal and other life-threatening behaviors and those that interfere with therapy and quality of life. Increase mindfulness, tolerance for distress, interpersonal effectiveness, and emotion regulation.

Stage 2. Move from quiet desperation to emotional experiencing.

Stage 3. Address problems in living, and move toward ordinary happiness/unhappiness.

Stage 4. Move from incompleteness to capacity for joy and freedom.

Seven randomized controlled trials have shown that DBT can be useful in treating borderline personality disorder. The initial trial by Linehan et al included 47 women ages 18 to 45 who met criteria for borderline personality disorder and had at least two parasuicide incidents in the previous 5 years, with one in the previous 8 weeks. Treatment lasted 1 year, and subjects agreed to stop other individual psychotherapy if...
assigned to DBT.

Subjects were then randomly assigned to either DBT or “treatment as usual” in the community. In the various DBT studies, treatment-as-usual has included community therapists, Department of Veterans Affairs outpatient treatment, client-centered therapy, and treatment by persons identified by their peers as experts in their communities.

Subjects were assessed every 4 months while in treatment and for 1 year thereafter. DBT was more effective than usual treatment in:

- reducing suicide attempts and self-injury
- decreasing premature dropout from therapy
- reducing emergency room admissions and length of psychiatric hospitalization
- reducing drug abuse, depression, hopelessness, and anger.

RECOMMENDATIONS

Some psychiatrists may find “borderline patients” frustrating and unpleasant to treat. DBT therapists, however, make two assumptions that can help anyone working with individuals with borderline personality disorder. To avoid falling into the trap of polarization with these patients, assume that:

- they are doing the best they can
- their efforts are insufficient to meet their needs.

They therefore need to do better, and the therapist’s job is to help them do so. Also assume that if you try to help a patient with borderline personality disorder, you will need help, too. We require DBT therapists to participate in consultation teams.

Training. DBT is a comprehensive program that requires familiarity with the manuals mentioned in this article (see Related resources). Some teams have learned DBT through self-study and consultation with other teams.

If you plan to offer DBT to patients with borderline personality disorder, we recommend that you be:

- trained in behavior therapy and CBT
- familiar with research on emotions and processes involved in emotion regulation.

If you have not had CBT training, find a behavior therapist to join your team or get consultation from a behavior therapist.

An intensive training course in DBT — with 2 weeks of instruction and case consultation and several months of consultation with someone well-versed in DBT — is an efficient way to become familiar with the most critical principles of the treatment. If you cannot train toward adherent delivery of the individual therapy, we recommend referring patients to someone trained in DBT.

References

6. Linehan MM, Dimeff LA, Reynolds SK, et al. Dialectical behavior therapy versus comprehensive validation therapy plus 12-step for...
the treatment of opioid dependent women meeting criteria for borderline personality disorder.


Related resources

Disclosure
Dr. DuBose is president and CEO and owner of DBT Center of Seattle, PLLC, and a speaker for Behavioral Tech, L.L.C.

Dr. Linehan is a shareholder in Behavioral Tech Research, Inc., which develops computerized training for DBT, a DBT trainer for Behavioral Tech, L.L.C., and the author of two books on DBT. She also receives research grants from the National Institute of Mental Health and National Institute on Drug Abuse.