

Living the Paradox: Finding Balance in Dialectical Dilemmas

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FOR EVIDENCE BASED
TREATMENT



Accuracy, Utility, and Risks Statement and Research Limitations

This presentation discusses on the three main dialectical dilemmas in Dialectical Behavior Therapy (DBT) provides accurate, evidence-based information to help providers effectively implement DBT. The goal is to equip providers with practical tools to improve their therapeutic work and client outcomes.

Providers should be mindful of the risks, including the potential for overgeneralization and the importance of recognizing DBT's limitations—it may not be suitable for all clients or situations. Supervision and ongoing education are recommended to ensure effective application and address challenges that may arise in clinical practice. DBT principles can be applied across diverse populations but need to be adapted when considering cultural norms, values, family dynamics, and social contexts.



Cultural Considerations for DBT

- DBT was developed in a Western context but is used globally.
- Cultural sensitivity is essential for effective implementation.
- Culture and context shape client behaviors within DBT's dialectical dilemmas.



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- ▶ Conflicts of Interest: None
 - ▶ Commercial Support: None



Use of AI

Artificial intelligence (AI) was used to support the development of this presentation. AI assistance included:

- Structuring and expanding content on DBT dialectical dilemmas
- Clarifying and summarizing clinical concepts
- Generating clinical scenarios and reflection questions
- Formatting APA citations for reference slide





Agenda

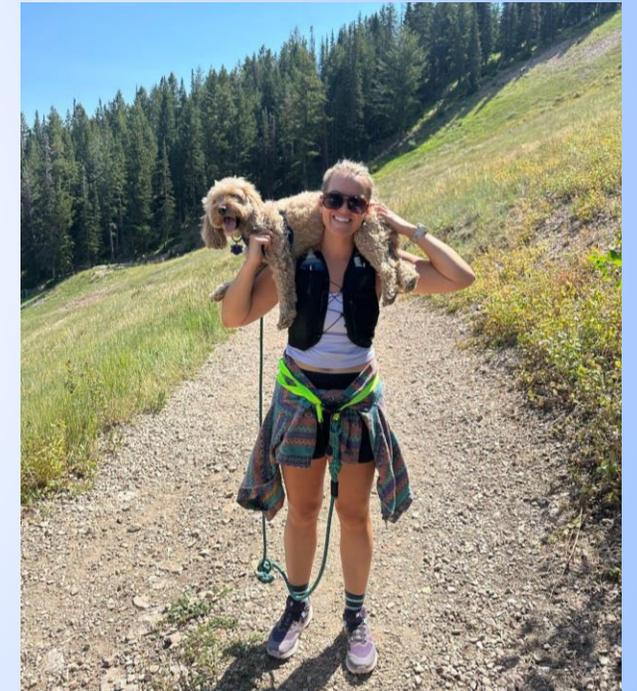
- ▶ Introduction
- ▶ DBT foundations refresher
- ▶ Discussion of the secondary treatment targets
- ▶ Examples of therapist errors & how to avoid them
- ▶ Clinical integration scenario & application
- ▶ Treatment Solutions
- ▶ Questions



Introduction

Rebecca Price, LCSW

- ▶ MSW from the University of Georgia
- ▶ Clinical Therapist at UCEBT
- ▶ Foundationally Trained in DBT through Behavior Tech
- ▶ DBT therapist at Residential/Day Treatment program in Atlanta





Primary Goals

- ▶ Understand the theoretical framework of the three dialectical dilemmas established by Marsha Linehan
- ▶ Recognize how and why the dilemmas manifest in client's behaviors
- ▶ Apply therapeutic strategies to address dilemmas effectively





Of note...

- ▶ Treatment solutions won't mention distress tolerance skills



Dichotomous thinking and dialectics

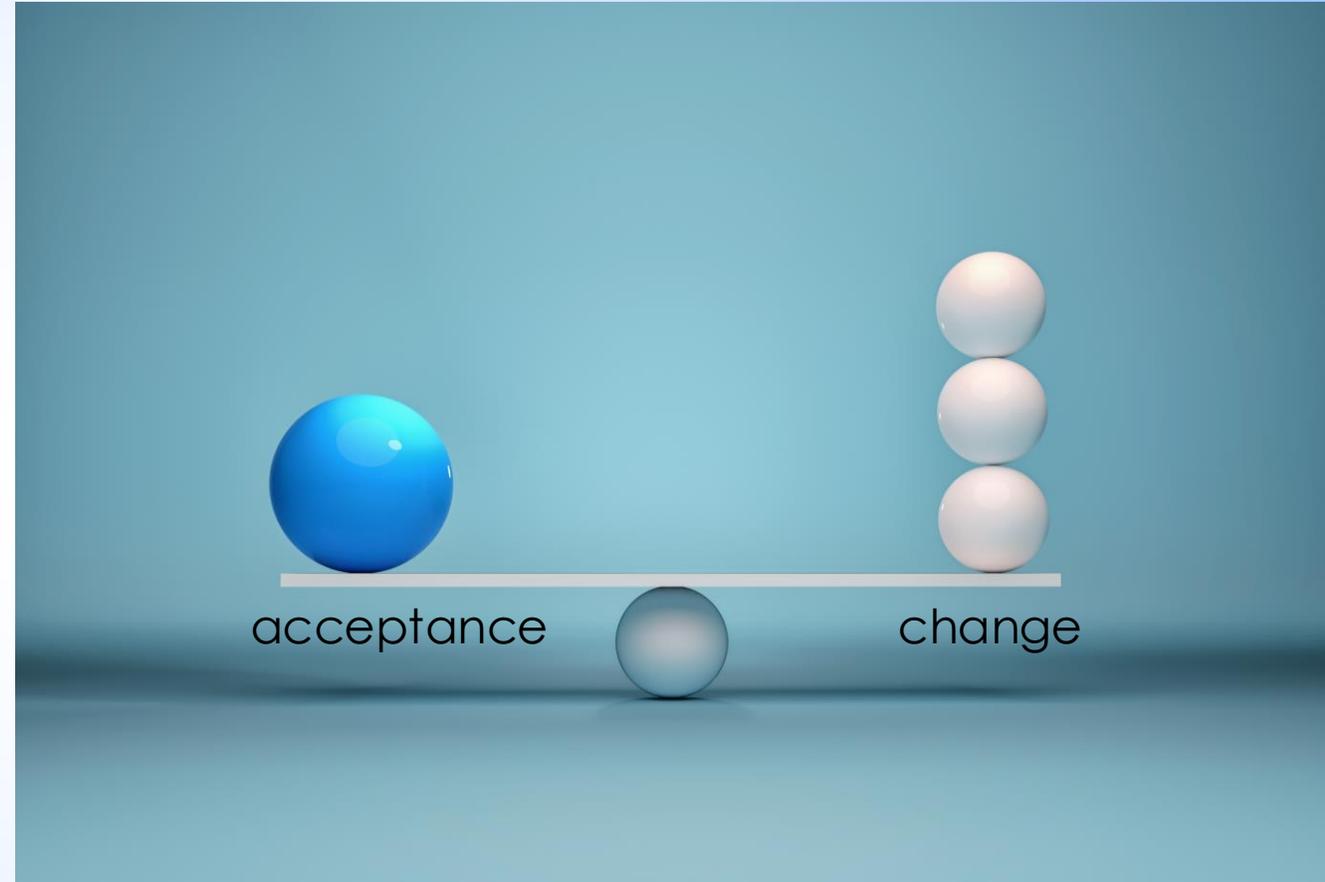
Dichotomous thinking is getting stuck in the thesis or antithesis and the inability to move to a synthesis

dialectics is “the reconciliation of opposites in a continual process of synthesis” (Linehan, 1993, p. 19)

Focus of treatment is moving client toward dialectical behavior patterns by finding balance and integration in thoughts, actions, and emotional responses to life situations

Acceptance of a paradoxical reality

Walking the middle path



Biosocial Theory

➤ BIOLOGICAL

- Emotional vulnerability: more sensitive to emotional stimuli, higher frequency of experiencing emotions, emotions may seem to come out of nowhere, at a higher intensity, and have a longer lifespan
- Impulsivity: Harder to control impulse urges, act without thinking, mood-dependent behaviors that seem impossible to control

➤ INVALIDATING/INEFFECTIVE SOCIAL ENVIRONMENT

- Emotion regulation: invalidates emotions and expression of emotion, ineffective modeling of coping skills
- Reinforce out of control emotions and actions (potentially unknowingly)
- Demand for you to be different, but doesn't explain how to change

➤ TRANSACTIONS

- Biology combined with the social environment influence a person which impacts how the person shows up in their environment. The response of the environment to the person influences them..; and so on





Primary Treatment Targets

- ▶ Life interfering behaviors
- ▶ Therapy interfering behaviors
- ▶ Quality of life interfering behaviors



Secondary Treatment Targets

Dialectical Dilemmas:

biological Consequences

vs.

social/environmental consequences

Emotional Vulnerability

Self Invalidation

Active Passivity

Apparent Competence

Unrelenting Crisis

Inhibited Grieving

- ▶ Discomfort of extreme points on each dimension insures individual swings back and forth between polarities
- ▶ Central dilemma of DBT therapy is a client's inability to balance these extremes by coming to a synthesis
- ▶ These targets perpetuate the primary target behaviors



Secondary Treatment Targets aren't...

- ▶ Diagnostic or definitional for BPD
- ▶ Complete summary of borderline characteristics
- ▶ Universal behavioral patterns for people with BPD
 - ▶ Don't assume Presence of dilemmas – assess
 - ▶ Set of hypotheses to be tested



Step-by-step approach to treating dialectical dilemmas:

1. Collaborative assess with client
 1. Look for links between the patterns and what's getting in the way of them currently achieving their life worth living goals
2. Identify, describe, and validate patterns
3. Develop individualized skills plan to resolve each dilemma
 - ▶ Make sure plans align with clients identified values, life worth living goals, and treatment plan
 - ▶ Add to diary card
 - ▶ Track behaviors to decrease and skills to increase
 - ▶ Assess what potential barriers could get in the way of utilizing skills in moment and cope ahead
4. Address dilemmas when they occur in session and reinforce any time client moves to synthesis



Emotional Vulnerability

- ▶ Biological sensitivity to emotional stimuli
- ▶ intense reactivity to emotional stimuli, high emotional sensitivity, and a slow return to baseline
- ▶ Consequences:
 - ▶ Negatively impacts clients' ability to engage in effective coping behaviors
 - ▶ Increases likelihood of experiencing dichotomous thinking, obsessive and perseverative thoughts
 - ▶ Leads to client feelings of despair, hopelessness, and helplessness
 - ▶ Client feels out of control and unpredictable
 - ▶ Behavioral, interpersonal, self, and cognitive instability
 - ▶ Suicidal ideation and behaviors can occur due to not feeling like they can stand the emotional pain any more



Self-Invalidation

- ▶ Client implementing the invalidating characteristics from their invalidating environment as an attempt to inhibit emotional expressions and experiences
- ▶ Invalidating environments examples:
 - ▶ Child being told their emotion is too much, wrong, they shouldn't be feeling that way, or they're overreacting
 - ▶ Child being punished for expressing an emotion leads child to feel shame
- ▶ Consequences:
 - ▶ Invalidating environments leads person to respond to their own emotions with shame, criticism, and punishment
 - ▶ Clients' invalidation leads to lack of trust in self due to denial of their reality. This inhibits development of an identity or confidence in self
 - ▶ Person scans environment for how to think and feel instead of trusting internal experience
 - ▶ Person may set unrealistic behavioral expectations on themselves which leads to failure and giving up. This leads to experiencing excessive guilt



Emotional Vulnerability vs. Self-Invalidation cultural influences:

- ▶ Collectivist cultures emphasize emotional restraint and group harmony
- ▶ Emotional suppression can increase self-invalidation
- ▶ Stigma around mental illness may amplify emotional avoidance



Emotional Vulnerability (biological consequences)

VS.

Self-Invalidation (environmental consequences)

- ▶ Biosocial Theory at play
- ▶ Dilemmas for client:
 - ▶ Who to blame?
 - ▶ Who is right?
- ▶ Inability to accept both sides causes client to vacillate between polarities





Identifying dilemma in session:

What You Might Hear

“I don’t know why I’m so upset—nothing even happened.”

“I’m too sensitive. I should be able to handle this by now.”

“I can’t trust myself to make decisions.”

“It doesn’t matter anyway.”

What You Might See

Client crying, then minimizing emotions or apologizing for them

Sudden shifts in emotion; intense reactivity followed by shame or withdrawal

Looks to therapist for permission or reassurance, second-guesses self

Nonchalant tone while describing very painful content

Interpretation

Internalized invalidation; learned to mistrust or suppress feelings

Emotional vulnerability and internalized critical voice

Lacks confidence in internal experience or judgment

Affective numbing/denial as defense against shame

Case Example

- Sarah (client), a 28-year-old woman diagnosed with BPD, received constructive feedback from her boss which Sarah perceives as harsh, humiliating, and criticizing. This triggers shame in Sarah, and she begins thinking “I’m a failure”, “I’m never going to be good enough”, “I’m stupid and can’t do anything right.” Sarah’s invalidating thoughts persists throughout the rest of the day, and she ruminates on the conversation all night. These thoughts intensify her shame and anger. At work the next day, her boss asked her how her evening was; causing Sarah to lash out at her boss and impulsively quits her job.



Treatment Solutions

- ▶ Therapist balances validation and change strategies
 - ▶ Validate the essential wisdom of each clients' experiences especially their vulnerabilities and sense of desperation AND teach the clients skills necessary for change and utilize capability enhancement strategies
- ▶ Emotional Vulnerability: Increasing emotional modulation and decreasing emotional reactivity
 - ▶ Mindfulness: (what and how skills)
 - ▶ observe and describe; non-judgmentally
 - ▶ Not getting caught up in right vs. wrong, good vs. bad
 - ▶ Stay in the moment- one thing at a time
 - ▶ Focus on effectiveness
 - ▶ Emotion regulation: labeling emotions, check the facts, opposite action
- ▶ Self-Invalidation: increasing self-validation and decreasing self-invalidation
 - ▶ Mindfulness: activating wise mind, observe and describe
 - ▶ Dialectical strategies: walking the middle path; changing either, or to both, and





Examples of therapeutic errors and skillful adaptations

Therapist Error	Why It Happens	How It Reinforces the Dilemma	What to Do Instead
Minimizing the client's distress (e.g., "You're being too hard on yourself")	Therapist is trying to reassure or reduce emotional intensity	Echoes invalidation, increases client shame	Use accurate validation. Reflect the logic of the client's emotion: "It makes sense you'd feel overwhelmed given what you've been through."
Jumping to skill-teaching too quickly	Desire to help "fix it" or reduce clinician discomfort	Client feels feelings are not tolerated or welcomed	Use the validation sandwich: validate emotion → acknowledge its function → introduce skill for change Frame sensitivity as part of biosocial model: "Your nervous system is tuned to high sensitivity—it's not your fault, and it is your responsibility to manage it."
Over-pathologizing emotions or reactions	Misreading sensitivity as dysfunction	Client feels "broken" or defective	

Active Passivity

- ▶ Tendency to approach problems passively and helplessly (passive self-regulation style), instead of actively and confidently, and when under extreme distress to demand from the environment solutions to solve their problems
- ▶ Client is active in getting others to solve their problems, and passive in solving problems/regulating behaviors independently
- ▶ Client believes they can't solve the problem, or their problem-solving efforts won't work
- ▶ Overwhelming belief that others have the solution for their problem



Consequences of Active Passivity

- ▶ Low self-efficacy
- ▶ High dependence on others to solve problems
- ▶ Emotional reliance on others to regulate emotions
- ▶ When pain is high and tolerance for distress is low clients will ineffectively ask for help by clinging to and demanding others
- ▶ These behaviors negatively impact relationships- relationship partners may distance themselves which elicits clients' fear of abandonment which in turn increases frantic attempts to save relationship and avoid abandonment
- ▶ Suicidal gestures and behaviors



Apparent Competence

- ▶ The tendency to appear competent and the ability to cope with everyday life circumstances, but at other time their behaviors are so ineffective and unexpected making it seem like their competencies never existed
- ▶ Influencing factors:
 - ▶ Mood-dependent and situation-specific learning
 - ▶ Difficulty effectively communication difficult and/or vulnerable emotions
 - ▶ Adopting beliefs of external environment and social signaling it (affect incongruence)
- ▶ Consequences:
 - ▶ Therapist may mistakenly assume client is more competent than they actually are
 - ▶ Environment could blame client or say “you're not trying hard enough” or “you’re being manipulative”
 - ▶ Suicidal ideation and gestures



cultural and sex-role stereotypes influence:

- ▶ Historically, research shows:
 - ▶ females tend to seek help from others and are more likely to develop learned helplessness
 - ▶ Females have a higher tendency of blaming themselves/their own abilities and giving up at a higher frequency compared to male counterparts
- ▶ The characteristic of being dependent of others also might not be seen as pathological in other cultures
- ▶ Hierarchical cultures promote submissiveness to authority, increasing passivity
- ▶ Passivity may be reinforced by family dynamics in Latinx, Asian communities





Active Passivity
(biological
consequences)

VS.

Apparent Competence
(environmental
consequences)

- ▶ Interpersonal targets
- ▶ Dilemma wouldn't exist if other people weren't involved
- ▶ Dilemma for client:
 - ▶ Helplessness vs. competence
 - ▶ Out of control vs in control
 - ▶ Needing help vs. not needing help



Identifying dilemma in session:

What You Might Hear

“What do you think I should do?”

“I’m fine—I’ve just been busy.” (when turning in a blank diary card)

“I usually just wait and hope things get better.”

“I’ve always been the strong one in my family.”

What You Might See

Blank stare when asked to problem-solve; difficulty identifying goals

Appears upbeat, but reports escalating problems later in session

Avoids acting even when consequences are mounting

Pride in independence, followed by tearfulness or overwhelm

Interpretation

Client is deferring agency to therapist—signals active passivity

Apparent competence—emotional needs avoided and masked by externally appearing functional

Passivity; relies on circumstances or others to intervene

Image of competence may obscure unmet emotional needs



Case Example

- ▶ Jason reports feeling “stuck” to his therapist. He expresses feeling powerless, helpless, and unsure how to manage everyday challenges. He reported procrastinating on important tasks for school causing his grades to plummet. Through doing a missing links analysis, therapist and Jason identify deficits in his ability to ask for help out of fear of appearing weak, incapable, or failure to his family members, friends, and/or teachers. Jason also identified history of his parents talking to the school after periods of avoidance/procrastination and the school changing his deadlines/offering extra credit. Jason named teachers seemed shocked by his inability to complete assignments due to appearing competent during class.



Treatment Solutions

- ▶ Therapist role:
 - ▶ Balance the client's capabilities AND deficiencies
 - ▶ Flexibly shifting from supporting/validating client and asking for them to change
 - ▶ Teach skills
- ▶ Active Passivity: increase active problem solving and decreasing active-passivity behaviors
 - ▶ Mindfulness: observe and describe, stay present in the moment, challenge fortune telling and catastrophizing, let go of right vs. wrong, and focus on effectiveness
 - ▶ Problem solving: remind self of past skillful experiences, ask self: what skills can I use? What has worked effectively before?, problem solving skills
- ▶ Apparent Competence: Increasing effective communication of emotions and competencies and decreasing mood dependency of behaviors
 - ▶ Mindfulness of current emotions
 - ▶ Interpersonal effectiveness: DEARMAN, GIVE, FAST, clarifying objective (self-respect, relationship effectiveness, getting objective met)



Examples of therapeutic errors and skillful adaptations

Therapist Error	Why It Happens	How It Reinforces the Dilemma	Correction / What to Do Instead
Over-functioning (solving client's problems for them)	Therapist feels urgency to help or discomfort with silence	Reinforces learned helplessness, discourages agency	Ask process questions: "What options have you considered?" or "What's worked before?"
Assuming competence based on articulate or organized presentation	Client is articulate or high functioning in other areas	Therapist underestimates internal distress, needs go unmet	Ask specifically about internal experience and skill use: "What skills did you use during that situation?"
Withdrawing support too soon	Misjudged readiness due to client's independence	Client experiences abandonment	Balance support and challenge: "You've done a lot well—where do you see areas in your life where you still struggle?"



Unrelenting Crisis

- ▶ State of chronic, overwhelming crisis
- ▶ Debilitating experience due to clients' reactivity and chronic nature of stressful events
- ▶ impedes on client's ability to return to baseline before another stressful event occurs- this reoccurring experience leads client to emotional burn-out and mental exhaustion
- ▶ Contributing factors:
 - ▶ Temperamental factors increase client's reactivity to emotional stimuli and impact the speed at which they return to baseline
 - ▶ Client's inability to tolerate distressing emotions coupled with engaging in maladaptive behaviors to avoid experiencing emotions perpetuates stressors
 - ▶ Interpersonal ineffectiveness and existing in an invalidating environment increases potential for relationship stressors





Consequences

- ▶ Parasuicidal acts, threats of suicide, and suicidal behaviors
- ▶ Interference with treatment planning
- ▶ Easy for client and therapist to get lost in the weeds of each crisis- if a therapist attempts to help client solve each crisis a client experiences- little progress will be made



Inhibited Grieving

- ▶ Pattern of repetitive, significant trauma and loss coupled with inability to fully experience, integrate, or resolve events
 - ▶ Loss can be concrete or perceptual
 - ▶ People with BPD and/or people who engage in parasuicidal behaviors typically have experienced at least one or more loss at an early age

Difficulties tolerating emotions that come with grief and difficulty moving successfully through all stages

Perpetually in a state of avoidance of experience(s)

Client inhibits grieving process perpetuating effects of loss or trauma

Due to dichotomous thinking, client's unable to believe pain will end, so instead they resort to avoidance/inhibition coping mechanisms (substance use, risky behaviors, gambling, etc.) typically elicit new crisis





Unrelenting Crisis vs. Inhibited Grieving

Cultural Influences:

- Collectivist and trauma-exposed populations may experience prolonged stress
- Grief rituals and timelines vary across cultures
- Suppression of grief may be normative, not pathological





Unrelenting Crisis (biological consequences)

VS.

Inhibited Grieving (environmental consequences)

- ▶ Experience of each extreme intensifies causing the swing from polarities to intensify and persist
- ▶ Dilemmas for client:
 - ▶ Inability to inhibit emotions when, at the same time, in a state of perpetual crisis
 - ▶ Inhibition of emotions in short term may feel helpful for client because they can avoid experiencing the overwhelming emotions; in the long turn, typically create new crisis due to maladaptive coping choices





Identifying dilemma in session:

What You Might Hear

“It’s always something—my life just doesn’t slow down.”

“I don’t want to talk about the past—it’s over.”

“I can’t afford to fall apart.”

“I’m always waiting for the next thing to go wrong.”

What You Might See

Reports back-to-back crises; no pause to reflect or grieve

Flat affect when discussing major losses or trauma

High-functioning in caregiving roles; never discusses their own needs

Catastrophic thinking, hypervigilance, exhaustion

Interpretation

Crisis cycle driven by avoidance of unresolved pain

Emotional suppression; fear of grief or emotional flooding

Internalized pressure to “stay strong”; avoids vulnerability

Belief that grief or slowing down = collapse; crisis becomes coping

Case Example

- ▶ Maya grew up in an invalidating home environment. Her mom died when Maya was 11, and her dad became distant, threw himself into his work, and would come home, drink, and had an explosive temper. Maya took on parenting her little brother and didn't feel she ever grieved the loss of her mom. Maya is now 40 years old and just started treatment. She described her work as a constant stressor, going home and getting in arguments with her husband regarding their children, finances, household responsibilities and lack of intimacy. Maya stated, "I feel like I'm on a never-ending roller coaster and I don't have time to catch my breath before the next drop". When asked how she copes, Maya said "sometimes I leave the house in the middle of arguments with my husband and drive recklessly. I've avoided going home and instead get drunk at a bar. I'm also addicted to playing gambling slots games on my phone in bed."



Treatment Solutions

- ▶ Therapist role:
 - ▶ Help the client face loss and traumatic event and to effectively experience and express emotions and reactions to grief
 - ▶ Instill hope that a life is worth living even after experiencing extreme pain and trauma
 - ▶ Teach skills
- ▶ Unrelenting crisis: Increasing realistic decision making and judgment while decreasing crisis-generating behaviors
 - ▶ Mindfulness: observe and describe, stay present in the moment, challenge fortune telling and catastrophizing, let go of right vs. wrong, and focus on effectiveness
 - ▶ Activate "wise mind"
 - ▶ Emotion regulation: increasing pleasant events in the short-term and long-term
 - ▶ Reality acceptance skills: willingness, turning the mind, radical acceptance
- ▶ Inhibited grieving: increase emotional experiencing while decreasing inhibited grieving
 - ▶ Mindfulness: observe and describe, stay present in the moment, challenge fortune telling and catastrophizing, let go of right vs. wrong, and focus on effectiveness
 - ▶ Exposure: avoid avoiding coupled with distress tolerance skills



Examples of therapeutic errors and skillful adaptations

Therapist Error	Why It Happens	How It Reinforces the Dilemma	Correction / What to Do Instead
Focusing only on current crisis week-to-week	Therapist feels pulled into urgency and problem solving	Misses underlying grief or trauma driving behavior	Step back to look for themes: “We’ve had a few similar situations—what do you notice about the pattern?”
Avoiding grief due to fear of destabilizing client	Therapist feels unsure how to hold space for intense emotions	Grief remains unresolved, avoidance continues	Pace slowly and check in for consent: “Would it be okay to talk about a memory or moment connected to that loss?”
Invalidating avoidance-based coping	Therapist labels behavior as resistance	Client feels misunderstood, becomes defensive	Normalize avoidance as protective: “It makes sense to avoid pain that feels overwhelming—but avoiding too long can keep you stuck.”



Diary Cards and Behavior Chain Analyses

- ▶ Diary cards = daily data to detect patterns linked to dilemmas
 - ▶ Clients log daily ratings of emotions, urges, behaviors (e.g., self-harm, isolation, avoidance), and skill use
 - ▶ Helpful tool for therapist to detect patterns that reflect dilemmas
 - ▶ Example: client reports intense shame paired with high urges to isolate, and denied using skills
 - ▶ Example: Client reports low intensity of emotions and high urges to engage in risky behaviors
- ▶ Chain analyses = in-depth tool to understand the function of behaviors driven by dialectical dilemmas
 - ▶ breaks down an event: from prompting event → thoughts → feelings → behavior → consequences also highlights impacts of vulnerability factors (PLEASE)
 - ▶ A client engaged in self-harm after being criticized. The chain shows:
 - ▶ Prompting event : Boss's feedback
 - ▶ Feeling: humiliated
 - ▶ Vulnerability: Sleep-deprived, argument with partner that morning, headache, hadn't eaten breakfast or lunch
 - ▶ Thought: "I'm a failure"
 - ▶ Feeling: shame
 - ▶ Behavior: Self-harm
 - ▶ Dilemma Identified: Emotional Vulnerability vs. Self-Invalidation



Skills deficits

- ▶ Prompting event : Boss's feedback
- ▶ Feeling: humiliated
 - ▶ Check the facts, opposite action
- ▶ Vulnerability: Sleep-deprived, argument with partner that morning, headache, hadn't eaten breakfast or lunch
 - ▶ ABC PLEASE
- ▶ Thought: "I'm a failure"
 - ▶ Activating wise mind, dialectical and non-judgmental thinking
- ▶ Feeling: shame
 - ▶ (depending on intensity)distress tolerance: self-soothe or emotion regulation: check the facts and opposite action to shame
- ▶ Behavior: Self-harm
 - ▶ Distress tolerance, phone coaching





Clinical integration

Scenario 1: A client repeatedly texts their therapist between sessions asking for help solving non-urgent issues. In session, they say, “I just can’t do anything without someone walking me through it.”

Questions:

What dilemma is likely occurring?

What might be reinforced if the therapist continues solving problems?

how could you promote skill use while maintaining the alliance?





Clinical integration

Scenario 2: A client shows up well-dressed, smiling, and talks about how much they've been helping others. When asked about their own needs, they hesitate and say, "I'm fine. Others have it worse."

Questions:

What might the client be avoiding?

How could you gently assess the gap between presentation and internal experience?

What skill or intervention would support emotional expression?



Clinical integration

Scenario 3: Jordan, a 24-year-old client, tells you that after a small disagreement with their partner, they felt "out of control emotionally" and spent the evening crying and blaming themselves. The next session, they say, "It's ridiculous that I reacted like that. I'm being dramatic. I shouldn't even bring this up again."

Questions:

What language or behaviors suggest emotional vulnerability?

How is self-invalidation showing up?

What might you validate, and what skill might you introduce?

What therapist response could unintentionally reinforce this dilemma?



Summary:

DBT addresses extreme behavioral, cognitive, and emotional patterns by balancing acceptance and change

Dialectical dilemmas reflect struggles in regulating self, others, and emotions

Emotional Vulnerability vs. Self-Invalidation

Key Issues: Heightened emotional reactivity, internalized shame, harsh self-judgment.

Core Skills:

Mindfulness (What & How Skills)

Emotion Regulation (Check the Facts, Opposite Action)

Self-Validation techniques

Wise Mind activation

Active Passivity vs. Apparent Competence

Key Issues: Dependency on others to problem-solve, masking needs, ineffective help-seeking.

Core Skills:

Interpersonal Effectiveness (DEAR MAN, GIVE, FAST)

Problem Solving (Identify options, weigh consequences)

Mindfulness of current emotions & needs

Challenge all-or-nothing thinking

Unrelenting Crisis vs. Inhibited Grieving

Key Issues: Chronic emotional overload, trauma, avoidance of grief.

Core Skills:

Distress Tolerance (TIP, Self-Soothing, IMPROVE)

Mindfulness (Present moment, Radical Acceptance)

Emotion Regulation for grief processing

Cope Ahead Planning



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