Advanced DBT-Informed Work with Dysregulation

THE TALKING THERAPIES UK PRACTITIONER SERIES



Advanced DBT-Informed Work with Dysregulation

Secondary targets, dialectical dilemmas, the consultation team, and dysregulation beyond borderline presentations.

Advanced level · 14 hours of continuing professional development

TALKING THERAPIES UK

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First edition, 2026.

This manual accompanies the Advanced DBT-Informed Work with Dysregulation course in the Talking Therapies UK Digital Classroom, from which its content is drawn and against which it is kept current.

Revision 4. This printing was set on 10 November 2026 from the course as it stood that day.

A note on the clinical material. Every case in this book is a fictional composite written for teaching. No real person appears in it, however disguised. Nothing here constitutes clinical supervision, and nothing in it replaces the judgement of a qualified practitioner working within their competence, their professional body's code and their local governance. Where guidance is cited it was current at the date of this edition; readers must check the standing of any guidance before relying on it.

Set in Poppins and Roboto, the Talking Therapies UK typefaces. Figures drawn by the Talking Therapies UK teaching-diagram engine.

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How to use this manual

Behind every crisis behaviour sits a pattern, and behind the pattern sits a dilemma. Advanced DBT works at that second level: the dialectical dilemmas and secondary targets that explain why the same storms recur, and the treatment strategy that shifts them. This course teaches that level of the model, for experienced practitioners working with significant dysregulation.

You will study the three classic dialectical dilemmas, emotional vulnerability against self-invalidation, active passivity against apparent competence, unrelenting crisis against inhibited grieving, and learn to formulate and treat the secondary targets they generate. You will examine the consultation team as DBT's treatment for the treater, the structure that keeps clinicians within the frame and within their own skin. The second module widens the lens: Lynch's Radically Open DBT and the overcontrolled presentations standard DBT was never designed for, and the dysregulation lens applied across diagnoses, from eating disorders to substance use.

Extended written lessons with key points and case-strategy practice tasks, supported by a study tutor. Fourteen hours of CPD, around a year of access, a final assessment, and a personalised certificate on passing. For clinicians who want DBT's full intellectual depth.

This manual is the written form of a course taught in the Talking Therapies UK Digital Classroom. It is set at advanced level and carries 14 hours of continuing professional development for practitioners who complete the accompanying course and its assessment.

It is written to be read in order. Each part opens with what it is for; each chapter teaches one idea to a working depth and closes with the points worth keeping and a practice task that converts reading into something you do. The tasks are the part most often skipped and the part that most reliably changes practice, and several of them are designed to be taken to supervision rather than completed alone.

The figures are teaching diagrams rather than decoration. Each is the conventional form of a model you will meet in the literature and in

supervision, drawn in one visual language across the whole series so that the shape of an idea is recognisable wherever it reappears.

Where a chapter draws on published work, the reference is named in the text and gathered in the further reading at the back. Terms of art are defined in the glossary, which is worth reading straight through once before you begin.

What this manual will leave you able to do

- Apply DBT-informed practice to severe, chronic dysregulation, self-harm and suicidal behaviour within your service's limits
- Balance change and acceptance strategies moment to moment with highly sensitised clients
- Manage therapy-interfering behaviour, your own included, dialectically
- Use telephone-coaching principles and inter-session contact within clear, sustainable boundaries
- Apply the consultation-team ethos to protect fidelity and prevent burnout
- Evaluate the DBT evidence base, including adaptations and what full-programme delivery adds

PART 1

Dialectical Dilemmas and Treatment Hierarchy

This module covers managing dialectical dilemmas, consultation teams, and prioritizing targets in complex cases.

CHAPTER 1

Dialectical dilemmas and secondary targets

Lesson “Dialectical dilemmas and secondary targets”:

Marsha Linehan’s biosocial theory of borderline personality disorder (BPD) remains the conceptual backbone of dialectical behaviour therapy (DBT). At its core is the interaction between a biologically heightened emotional vulnerability and an environment that frequently invalidates that vulnerability. In her seminal work, Linehan identified three dialectical dilemmas that organise the lived experience of many clients who present with self-harm, suicidality, or other dysregulated behaviours. These dilemmas are not merely descriptive; they generate the secondary treatment targets that sit beneath the overt behavioural goals of reducing self-injury, binge eating, substance misuse, or other high-risk actions. In advanced DBT-informed work, the therapist’s primary task is to navigate these dilemmas with a dialectical stance, moving clients towards a synthesis that integrates the truths of each pole rather than forcing a binary shift to the opposite extreme.

The first dilemma pits emotional vulnerability against self-invalidation. Clients with a rawly permeable nervous system experience emotions with an intensity and rapidity that can feel overwhelming. Because many have internalised an invalidating upbringing—where expressions of distress were dismissed, punished, or pathologised—they learn to attack the very source of their suffering. The internal narrative often reads, “I am weak for feeling this way,” or “My emotions are a defect that must be hidden.” This self-critical stance fuels a vicious cycle: the more intense the affect, the harsher the self-judgement, which in turn amplifies the affect. The dialectical tension lies in recognising that the emotion is both a biologically grounded signal and a target for skilful modulation.

The second dilemma concerns active passivity versus apparent competence. Many clients have never been taught effective problem-solving strategies; they have been left to navigate complex life demands without scaffolding. In response, they oscillate between a sense of helplessness—feeling that no solution is within reach—and a

context-dependent competence that can lead others to overestimate the client's capacity. This competence often manifests as articulate, composed, and high-functioning behaviour that masks an inner sense of inadequacy. When the client presents as competent, the underlying deficits remain invisible, and the therapeutic focus may be misdirected towards "manipulation" rather than genuine skill-building. The dialectic here is between the authentic need for assistance and the client's tendency to rely on this context-dependent competence rather than openly seeking help.

The third dilemma is the unrelenting crisis versus inhibited grieving. Clients frequently live in a state of perpetual emergency, moving from one crisis to the next without a period of stability. Beneath this cascade of crises lies a body of unprocessed loss—often early attachment ruptures, bereavements, or trauma—that has never been mourned. Grief requires a stable context in which the painful affect can be experienced, labelled, and integrated. The relentless crisis environment, however, functions as an avoidance system, keeping the grief material out of consciousness. The dialectic therefore juxtaposes the external urgency of crisis with the internal urgency of mourning that remains suppressed.

These three dilemmas give rise to the secondary targets that DBT clinicians address once current high-priority primary targets have been stabilised or are not immediately present. The secondary targets are paired, each representing a pole of a dilemma: (1) increase emotion modulation while decreasing self-invalidation; (2) increase active problem-solving and genuine help-seeking while decreasing active passivity and apparent competence; (3) increase emotional experiencing, including grief, while decreasing mourning-inhibition. The therapeutic stance is dialectical: the clinician identifies which pole the client is currently occupying and guides them towards a synthesis that honours both truths. Pushing a client from self-invalidation straight to "you are perfectly fine" merely reinforces the invalidation; instead, a validated middle voice—"your sensitivity is real, it is biologically based, and you can learn skills to regulate it"—provides a stable platform for change.

In practice, this dialectical synthesis is cultivated through several DBT-informed interventions. Mindfulness skills are employed not only to observe emotion but to label it with a compassionate stance that counters self-criticism. Interpersonal effectiveness modules are used to teach clients

how to request help without feeling fraudulent, thereby weakening the façade of competence. Distress tolerance techniques, such as the “TIP” skill (Temperature, Intense exercise, Paced breathing, Paired muscle relaxation), are paired with exposure-based grief work that gradually re-introduces the client to the affect associated with loss in a safe, controlled manner. The therapist also utilises chain analysis to map how a crisis episode is linked to an underlying grief trigger, thereby making the invisible connection explicit.

A concrete worked example illustrates how these principles coalesce in an advanced case. Farrah, a 32-year-old woman, was referred after three emergency department presentations within six weeks, a threatened resignation from her senior managerial role, and the abrupt termination of a long-standing friendship. In her intake, the PHQ-9 score was 18, indicating moderately severe depression, and the GAD-7 was 14, reflecting moderate anxiety. Farrah’s narrative was dominated by statements such as, “I have to keep everything together, otherwise everything falls apart,” and, “If I show how upset I am, I’ll be seen as weak and lose my job.” The therapist began by stabilising the primary target of self-harm, which was absent but the risk was high given the crisis frequency.

During the first month, the therapist focused on the secondary target related to active passivity and apparent competence. Using chain analysis, a pattern emerged: each crisis was precipitated by an intrusive memory of her mother’s death six years earlier, a loss that Farrah had never mourned. The memory would surface during a demanding work task, triggering an overwhelming sense of abandonment. In response, Farrah would either shut down (active passivity) or launch into a frantic attempt to control every detail of the situation (apparent competence), both of which escalated the crisis. Recognising that Farrah was oscillating between the active-passivity and apparent-competence poles, the therapist introduced a synthesis statement: “You are capable of leading your team, and at the same time you can ask for support when the workload feels too heavy.” This validation was paired with a concrete behavioural contract to delegate one task per day, thereby practising problem-solving in a manageable context.

Simultaneously, the therapist addressed the emotional-vulnerability versus self-invalidation dilemma. In mindfulness practice, Farrah was guided to notice the bodily sensations that accompanied the memory of her mother’s death—tightness in the chest, a knot in the throat—without immediately

judging them as “weakness.” The therapist modelled a self-validation script: “It is understandable that you feel a deep ache when you think of your mother; your nervous system is responding to a real loss.” Over several weeks, Farrah reported a reduction in the PHQ-9 score to 12 and began to use the “PLEASE” skill (treat Physical illness, balance Eating, avoid mood-altering substances, balance Sleep, get Exercise) to stabilise her biological vulnerability.

The third secondary target—grief exposure—was introduced once the crisis frequency had decreased to one episode per month. The therapist employed a graded exposure hierarchy, beginning with Farrah writing a brief, factual account of her mother’s death, then progressing to reading a letter she had never sent to her mother, and finally, viewing a family photograph while naming the associated feelings. Throughout this process, the therapist maintained a dialectical stance, acknowledging that grief is painful yet also a necessary pathway to emotional integration. Farrah’s GAD-7 score fell to 9, and she reported that the “constant feeling of being on edge” had lessened, allowing her to experience moments of calm without the immediate urge to control the environment.

By the end of the six-month advanced DBT-informed programme, Farrah’s crisis tempo had shifted from a relentless cascade to isolated, manageable events that could be addressed with problem-solving skills rather than emergency responses. Her self-invalidation had softened; she could acknowledge her vulnerability without self-criticism. Most importantly, she had begun a genuine mourning process, attending a memorial service for her mother and sharing memories with a close friend. The synthesis achieved across the three dilemmas illustrates the power of secondary-target work: the surface behaviours were never the illness themselves, but the manifestations of deeper dialectical tensions that, once integrated, allowed lasting change.

In sum, advanced DBT-informed work with dysregulation requires clinicians to move beyond the first-order behavioural targets and to engage with the dialectical dilemmas that underlie them. The three dilemmas—emotional vulnerability versus self-invalidation, active passivity versus apparent competence, and unrelenting crisis versus inhibited grieving—generate paired secondary targets that must be addressed in tandem. The therapist’s dialectical stance involves identifying the client’s current pole, validating the

truth of that pole, and guiding the client towards a synthesis that incorporates both sides. This approach respects the client's lived experience, avoids the pitfalls of binary thinking, and aligns with the empirical foundations of DBT, which demonstrate that skill acquisition, emotional regulation, and interpersonal effectiveness are most durable when they are integrated rather than compartmentalised. The case of Farrah exemplifies how such synthesis can be operationalised, leading to measurable reductions in PHQ-9 and GAD-7 scores, a decrease in crisis frequency, and the emergence of authentic grief processing. By consistently applying this dialectical framework, advanced practitioners can facilitate profound, sustainable change for clients whose dysregulation has long been entrenched beneath the surface behaviours.

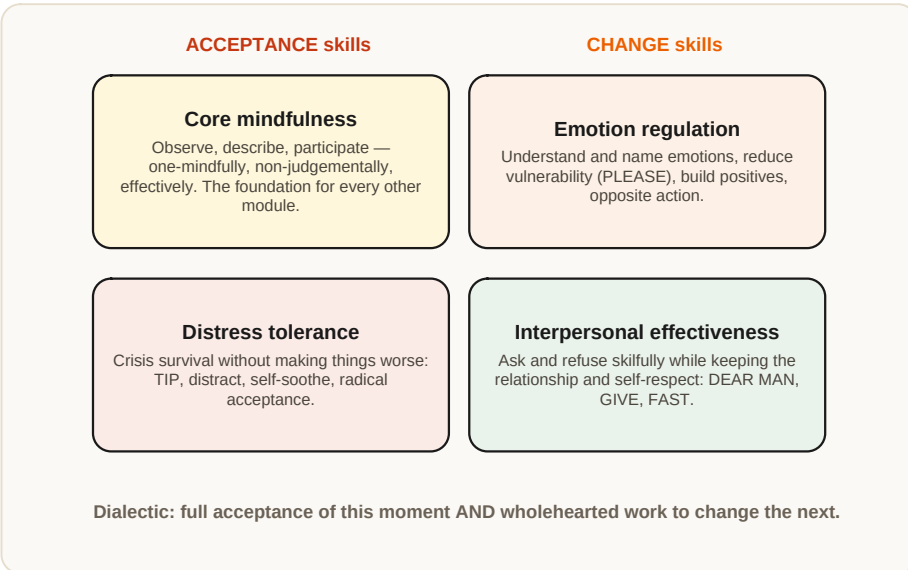


FIGURE 1.1 The four DBT skills modules

Linehan's skills curriculum balances acceptance and change. Mindfulness and distress tolerance teach how to be with experience as it is; emotion regulation and interpersonal effectiveness teach how to change it. Core mindfulness underpins all three of the others.

Points worth keeping

- Three dilemmas organise the presentation beneath the behaviours
- Secondary targets: modulate emotion, reduce self-invalidation, grieve, solve
- Move towards synthesis, never simply to the opposite pole

PRACTICE TASK

For "apparent competence", describe in two sentences how a capable-seeming client conceals drowning, and the secondary target this sets.

CHAPTER 2

The consultation team: treatment for the treater

DBT institutionalises what many other therapeutic modalities leave to the individual conscience of the practitioner: the systematic care of the clinician. The consultation team, as described in Marsha Linehan's original dialectical behaviour therapy manual and later elaborated by researchers such as Swann, Koerner and Harned, is not a case-review meeting, an administrative huddle, nor an optional peer-support group. It is a core treatment component, defined explicitly in the DBT protocol, with the therapist herself positioned as the patient. The premise is both empirical and unflattering: sustained work with chronic suicidality, intense rage, and pervasive despair reliably erodes clinicians, pushing them towards fear-driven practice, judgement, burnout, covert rule-bending or hardened emotional distance. No amount of individual virtue or personal resilience can fully protect a practitioner from these forces. The consultation team exists to catch this degradation early and to treat it, which is why classic DBT holds that a therapist who works without a team is not delivering DBT in its true sense.

The team operates on a set of agreements that function as its technology, each agreement grounded in dialectical philosophy and in the empirical findings of the DBT outcome literature. The dialectical agreement recognises that there is no absolute truth within the therapeutic context; when disagreements arise, the team seeks a synthesis that preserves the integrity of each perspective while moving towards a more functional stance. The consultation-to-the-patient agreement mirrors the client-to-client stance of DBT: we coach clients to manage their world, including other professionals, rather than intervening directly in the client's external environment. The consistency agreement, counter-intuitive yet liberating, states that we do not demand uniformity of each other; clients benefit from observing that different people have different limits, and this variability models a realistic, flexible approach to coping.

The observing-limits agreement requires each therapist to monitor and articulate their own limits, and for the team to observe these statements

without judgement, martyrdom or covert resentment. This is closely aligned with Linehan's emphasis on the therapist's awareness of their own emotional reactivity as a therapeutic tool (Linehan, 1993). The phenomenological-empathy agreement directs the team to search for non-pejorative interpretations of both the client's behaviour and each other's reactions, fostering a climate in which shame is replaced by curiosity. Central to the whole structure is the fallibility agreement, the keystone of the consultation team. All therapists are flawed; all will miss cues, breach agreements, become hooked, or experience counter-transference. The team's role is to notice these moments with compassion, not to prosecute or shame. In practice, this means that the consultation team functions as a therapeutic container for the therapist, mirroring the way the DBT skills group provides a container for the client.

Meetings are structured with a mindfulness opening, followed by an agenda that triages therapist need in the same way a client session triages risk. The standing question that defines the enterprise is simple yet profound: what does this therapist need in order to keep treating this client well? This question reframes the therapist's distress from a personal failing to a clinical signal that warrants systematic intervention. Regular, protected consultation is intended to reduce therapist burnout and to sustain fidelity to the model, and the team is one of the components of DBT as it was delivered in its trials (Linehan et al., 2006), although its own effect on therapists and clients has not been tested separately.

To illustrate the mechanism, consider the following worked example. A senior therapist, Emma, reports to her consultation team that her client, a 28-year-old woman with a history of chronic suicidal ideation, appears "stable" after a period of intensive skills training. Emma's report is delivered with careful neutrality, as the team's agreements require. The team, guided by phenomenological empathy, asks gentle, probing questions: "What has changed in your sense of the client's safety?" and "How have you been feeling about the phone-coaching limits you set?" Emma, feeling the safety of the team's non-judgmental stance, discloses that she has quietly stopped enforcing the agreed-upon phone-coaching limits, that she dreads the client's calls, and that she has not communicated this shift for a month. She describes a growing fear that her competence is eroding, a feeling that aligns with the observed-limits agreement.

The team does not audit Emma's practice; rather, it treats her. First, the team validates the fear as data about the case, acknowledging that the erosion of limits is a signal of therapist distress. Second, they walk the chain of limit-erosion together, mapping how the client's persistent crisis calls have triggered Emma's avoidance, how that avoidance has weakened the therapeutic contract, and how the unspoken breach may be feeding the client's sense of instability. Third, the team rehearses a limit-resetting conversation, role-playing Emma's upcoming discussion with the client, emphasising the DBT principle of "wise mind" communication. Finally, a team member volunteers to check in with Emma on Thursday, providing an external anchor that reduces isolation. Within the next week, Emma reinstates the phone-coaching limits, communicates the rationale to the client using a collaborative stance, and reports a measurable reduction in her own anxiety. The client's treatment improves, not because the client was the focus of the team's work, but because Emma, the therapist, was treated. This example encapsulates the core premise: the consultation team is a treatment component for the treater, not a supervisory audit of the client.

The transferability of this model to any setting where dysregulation is addressed at depth is direct. Any practitioner working with intense emotional dysregulation—whether in a DBT programme, a trauma-focused therapy, or an intensive outpatient service—needs an equivalent structure, deliberately built if the programme does not already provide one. The specification is modest: more than one colleague, regular and protected time, and an honest articulation of affect and the impact of the work on the therapist, spoken aloud rather than hidden behind case summaries. The fallibility norm must be explicit, allowing shameful material, dread, anger towards a client, or the temptation to bend a rule to surface while it is still small. Isolation is the failure mode of dysregulation work; not through ignorance, but through unwitnessed drift. When a therapist works alone, the subtle erosion of limits can go unnoticed until it culminates in a crisis, a breach of contract, or therapist burnout.

The consultation team, therefore, is DBT's answer to this failure mode, and its portable lesson is blunt: the clinician is part of the treatment system, degrades like any component, and deserves the same engineering. This perspective aligns with contemporary systems theory, which posits that every element in a therapeutic system must be maintained for the system to function optimally (Bateson, 1972). In DBT, the consultation team is the

maintenance protocol for the therapist component.

Implementing a functional consultation team requires attention to three practical pillars. First, the team composition must include at least two clinicians who share a common theoretical orientation and who are willing to engage in mutual vulnerability. Second, the meetings must be scheduled at regular intervals—ideally weekly—and must be protected from clinical duties, ensuring that the time is truly dedicated to therapist care. Third, the culture of the team must be explicitly articulated, with the agreements written and reviewed periodically, reinforcing the fallibility, non-pejorative interpretation, and observed-limits principles. When these pillars are in place, the team becomes a living embodiment of the DBT dialectic: it holds together the tension between acceptance of therapist vulnerability and the imperative to maintain therapeutic effectiveness.

Burnout is common in mental health work, about 40 per cent of professionals reporting emotional exhaustion in one meta-analysis (O'Connor, Muller Neff and Pitman, 2018), which is one reason the team attends to the therapist as well as the client. The consultation team is therefore best understood as a treatment component rather than a peripheral support.

In summary, the consultation team treats the treater, not the client, by operationalising a set of agreements that foreground fallibility, non-pejorative interpretation, and observed limits. Isolation is the failure mode of dysregulation work; the team prevents isolation by providing a container in which therapist distress can be witnessed, named, and addressed before it compromises client care. By embedding the consultation team within the DBT framework, practitioners honour the dialectical principle that change arises from the synthesis of acceptance and change, applied not only to clients but to the clinicians who serve them. The result is a more resilient therapeutic workforce, higher fidelity to evidence-based practice, and ultimately, better outcomes for the clients whose lives depend on the stability of the clinicians who support them.

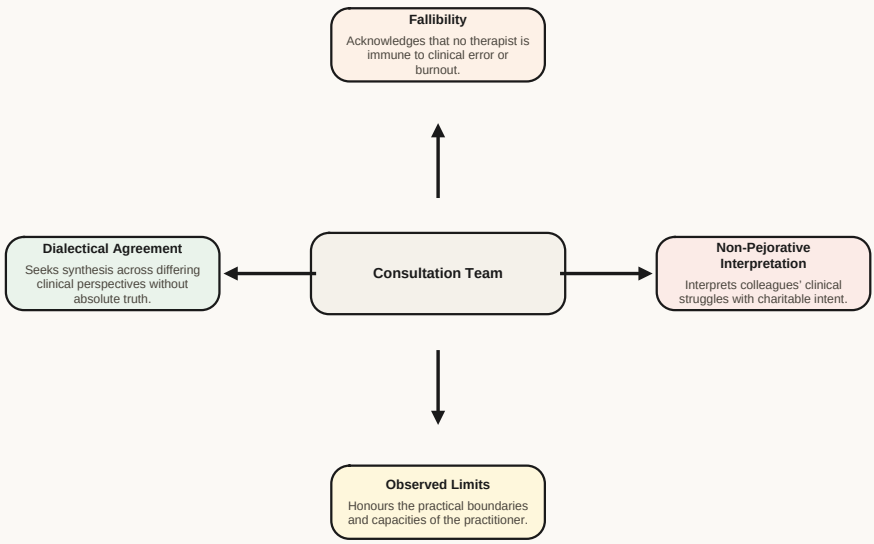


FIGURE 2.1 DBT Consultation Team Agreements

The core operational agreements that govern the consultation team. These principles protect the therapist from isolation and maintain fidelity to the treatment.

Points worth keeping

- The team treats the therapist, not the client
- Agreements: fallibility, non-pejorative interpretation, observed limits
- Isolation is the failure mode of dysregulation work

PRACTICE TASK

Identify your own consultation equivalent. If it does not meet the three agreements, name the gap and one step to close it.