How Does Art Therapy with Dialectical Behavioral Therapy Help With Borderline Personality Disorder and Post Traumatic Stress Disorder

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By:

Kristine Marie Lund

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Abstract

Finding more effective treatments for Borderline Personality Disorder (BPD) and Post Traumatic Stress Disorder (PTSD) is important to lessen the suffering, stigma, and heavy use on the mental health system. Art Therapy may help with Post Traumatic Stress Disorder with Borderline Personality Disorder according to current trends and neurobiological findings on how the trauma response works in the brain. Dialectical Behavioral Therapy has numerous studies siting its effectiveness for treating Borderline Personality Disorder. DBT may also be helpful for BPD with high rates of self-harm. BPD be Complex Trauma and is surrounded by controversies politically and culturally affecting new research directions for those who suffer from PTSD and Borderline Personality Disorder.
How Does Art Therapy with Dialectical Behavioral Therapy Help With Borderline Personality Disorder and Post Traumatic Stress Disorder

The Goal of this review is to research how Art Therapy can help with BPD and PTSD and how Dialectical Behavioral Therapy can help with BPD and PTSD. The researcher in this review has worked in a Dialectical Behavioral Therapy setting using Art Therapy as an adjunct therapy with Borderline Personality Disorders and other pathologies. Bias towards the applicability of Art Therapy with Trauma and Borderline Personality Disorder may be present due to the researchers own experience of the effectiveness using both therapies.

Trauma research has shown how the brain may react under extreme or chronic stress. The findings now point to a biological process that the brain may go through and explain a lot of the symptoms of trauma exposures. The trend is moving away from symptomology as pathology and being replaced with an understanding of coping and survival as normal mechanisms of trauma. Borderline Personality Disorder and Post Traumatic Stress Disorder have complexities that include controversies about what BPD really is and how trauma can play a role in the etiology of the illness. What really is BPD and how does it compare to trauma? This paper will research recent findings as well as theoretical, political, and cultural research comparing and contrasting both.

**Art Therapy and Neuroscience of Trauma**

A recent trend has evolved in Art Therapy as a recommended therapeutic advancement for those suffering from trauma. There are physiological links in neuroscience that now look at trauma as both physiological and psychological (Malchiodi, 2003). Implicit and explicit memory is key in understanding the trauma response. Implicit memory is non-verbal, sensory, related to the body, and emotional. This type of memory is unconscious and relates to the body. Explicit
memory is verbal, factual, conceptual, and related to ideas. Neuroimaging findings show that non-verbal response to imagery of Post-Traumatic Stress subjects, compared with controls, had diminished verbal consciousness and triggered intrusions of non-verbal memory (Trip, 2007; Tinnin, 2009). Many who experience trauma have difficulty when implicit memories are not linked to explicit memories. Basically the experiencing side does not communicate with the verbal side of the Limbic System. Art Therapy can quiet and calm the amygdala and promote a healthier coping response to balance the amygdala and hippocampus that cause the fight or flight response. What happens during a trauma is usually a freeze effect that is a survival mechanism in the Fight or Flight response. This animal-like behavior is a protection from pain and often is described by humans as being an out of body experience or not feeling a presence in space. Animals during an overwhelming threat show extreme docility and humans similarly respond displaying automatic obedience. At this point the normal cognition is compromised and consciousness fails. The verbal mind does not count this process into memory and often automatically rationalizes it away or disowns the event or that the events ever occurred (Gantt & Tinnin, 2009).

Art Therapy has the unique ability to bring the non-verbal mind front and center without obligatory censorship that the verbal mind possesses. The art captures the fleeting emotional message and the Art Therapist can work through the perception with the client. Art Therapists do not interject bias and work with the client on what is presented in the art. As the client steps back and looks at it, there is the opportunity to receive the emotional message and put words to it and gain meaningful insight (Tinnen, 1990).
Art Therapy and Mind/Body Connection

In light of new research on trauma, Art Therapy has the potential to integrate implicit (sensory) and explicit (declarative) memory that is often fragmented with clients suffering from events of trauma. Art Therapy can aid in self-regulating emotions and the bodies reactions to the trauma process (Malchiodi, 2010). Imagery derived from imagination can provide several levels of information processing. Visual expression involves complex sensory and emotional content, which originates in the parietal lobes and limbic system and then get forwarded to the prefrontal cortex where it can then be regulated (Lusebrink, 2010, p.169-170). The emotional expression of the visual art form is documented before the artist’s natural verbal censorship occurs (Tinnen, 1990). The Expressive Therapies Continuum (ETC) measures coordinating brain functions with visual art and can help therapists determine how a client is processing kinesthetic/sensory, perceptual/effective, and cognitive symbolic information. Each of these processes matches different parts of brain functions and could be useful tools in helping art therapists working with trauma (Lusebrink, 2010).

A thirty-year study linking neuroscience, specific trauma, PTSD, image conversion, and language translation, was conducted and there were many similarities in images produced by women who suffered sexual abuse and assault. Many images had disembodied eyes and wedges indicating unresolved traumatic experiences. The study indicates the usefulness of art therapy to engage, organize, and correct dysfunctional cognitions associated with trauma. When victim’s engaged in Art Therapy the artistic form was translated to the linguistic form resulting in full realization of the experience connecting both the mind and the body. The art became the documentation of the emotions and body sensations and a holding place for the client to convert and interpret meaning from the traumatic experience (Spring, 2004).
How Can Art Therapy Help Trauma

More research is coming out on how Art Therapy can be an effective tool for a variety of symptoms, age groups and disorders. In a compilation review of findings, outcome studies were organized so that Art Therapy students, clinicians, and readers could access the data and assess the strength and relevancy of findings in accordance of individual needs (Slayton, Archer, & Maryhurst, 2010). The first study sighted was with girls and young women who had been sexually abused (ages 8-16). There was statistical reduction on 9 out of the 10 Trauma Symptom Children’s Checklist (TSCC) for anxiety, PTSD, and dissociation scales in children. The second study was with children and young adults (ages 8-16) who had been sexually abused. Statistical reduction in Anxiety (p < .03), Post Traumatic Stress (p < .02), and Dissociation-Overt (p < .03) (Pifalo, 2002). The limitation of this study was the small sample size of 13.

This researcher found many smaller studies with single cases. One such single case found was based on processing trauma through Art Therapy and bilateral stimulation. This type of Art Therapy is based on a modified version of Eye Movement Desensitization and Reprocessing (EMDR) where a protocol is followed in alternating tactile and auditory bilateral stimulation. The theory is that it helps both the implicit and explicit memory process trauma. It works by focusing dual attention through taps and sounds. Old memory networks are activated (implicit) while attention is focused on the present (explicit) with external visual, auditory, or tactile cues. EMDR takes the client through upsetting memories while attending to new information as it becomes accessed and gradually processed through the brain (Tally, 2007). The difference here is that instead of visualizing the event the client is re-creating the event in art. In this case study the client (Betty) came in with a history of childhood sexual molestation and currently was having problems with her male supervisor. In the first scribble drawing, Betty perceived within
the lines a mother gazing at a child and missing that inner connection of the mother and child bond. In the second scribble drawing, she developed a butterfly in the upper corner walled off by a square. She described the butterfly as being “carefree with no hurt”. These earlier drawings were a starting point for brief Art Therapy. Betty portrayed her feelings of loss and feeling “worthless”. Betty shared negative beliefs she held about herself in childhood and recalled an early memory where she felt “powerless”. This memory would be the target memory. Bilateral stimulation was started with headphones and pulsars behind each knee. Betty drew her early memory of being un-loveable and was stopped to verbalize what she noticed after each picture and where she felt it in her body. Betty developed new associations of “unfair” and “irresponsible”. This process continues until Betty has a cognitive shift being, that her anger was not destructive and in fact, was fundamental to her healthy functioning. By using a modified version of EMDR with Art Therapy Betty was able to make new connections to alter her long held beliefs and create new cognitions. Betty was finally able to see her anger as “righteous” and “justified” (Trip, 2007).

This case study is a good example of how Art Therapy can help connect the verbal to the non-verbal in mediating trauma. The limiting factor is that it is only one case. More research is needed on a larger scale to show the therapeutic benefits of Art Therapy with modified bilateral stimulation.

Art Assessment

This researcher found many articles and few studies on assessment. Most Art Assessments were recommended for children including: The Human Figure Drawing Test (HFD), Kinetic Family Drawing (KFD), Draw A Person Test (DAP: SPED), (Brooke, 2004).
A study that compared several art assessment tools found Person Picking An Apple Tree was the top assessment recommended for measuring psychological states. Using a regression model found PPAT to be marginally satisfactory with the coefficients 0.61 and the rank correlation coefficient of 0.576. The statistical model used to discover effectiveness is considered a breakthrough to measure Art Assessments in the future. (Kim, Kang, Chung, & Hong, 2012).

The Formal Elements Art Therapy Scale (FEATS) using Person Picking An Apple From A Tree (PPAT) may help with evaluating trauma. Feats scale number 12 specifically measures the Person in the PPAT where sexual abuse and trauma may be noted in line quality of the person drawn (Brooke, 2004, p. 169). The FEATS is a measurement system that applies global variables to two-dimensional art. Originally it was used with a single assessment (PPAT). The FEATS measures 14 scales such as prominence of color, logic, problem solving, rotation and detail of objects to the environment.

Art Therapists are using parts of the FEATS with other assessments to coincide with the DSM. Gant supports this research and views it as an opportunity to permit greater “generalizability” across several different types of pictures and expanding the results (Gant, 2001). More studies are needed to show the effectiveness of Art Assessments in diagnosing psychiatric illness.

**How Can Art Therapy Help with Borderline Personality Disorder?**

There is much written about Borderline Personality Disorder but not a lot of research done about Art Therapy and BPD. A handful of case studies do exist and do show the effectiveness with the individuals presented. A highly regarded Art Therapist, Rubin’s takes the view of Objects Relations Theory and puts it in to practice with BPD. Inherent in the clinical use of Object Relations Theory there is a deep-seated understanding of childhood development lines
and how they affect adulthood. A sense of self and a differentiated other is fundamental in seeing
people as whole and not just to satisfy selfish needs. Early healthy attachment is of key
importance in this theory (Rubin, 2001). BPD often describes the extreme edge of ambivalent
attachment where the client is preoccupied with attachment signals and is not able to have
healthy ongoing relationships. Many times BDP clients can be engaging and seductive, making
people feel like there is no one else they would rather be with. The relationships are intense but
short lived when the client questions love, caring, and behavior in others that are often

In using art therapy to clearly define self and other there is a need for structure,
boundaries, clarity, and definition to support the chaotic and disorganized life clients with BDP
often lead. Art Therapy can be a gentle yet firm therapy that can clarify and connect the worlds
of language and image to a clearer understanding of the outer reality. Rubin’s further describes
the ambivalent attachment expressing it as being stuck in the rapprochement phase of separation-
individuation, basically the “Terrible twos” (Rubin, 2001, p. 63). A BDP client may be aware of
separateness yet frightened of aloneness and seeks both directions at the same time. As she/he
screams and ‘yells’ and says ‘no’ the child’s need for autonomy are enmeshed with the silent
need to be held, a need often rejected when the parent tries to come near. In a two year old this is
understandable. In an adult client, the picture can be confusing and exasperating (Rubin, 2001).
Rubin believes this is key to understanding how BPD operates and can be applied. The task of
the Art Therapist is to have a very clear perception of when the client is regressing and why they
seek relief and support. A passive approach is not the best holding environment for the BPD
client. Always present are the belief something or someone is all bad or all good. Art therapists
need to create gentle but clear boundaries to deal with the splitting that occurs with extreme
polarization of emotions and beliefs. In order to be effective the Art Therapist should not be taken in by the rollercoaster of intense emotion. According to Rubins the paradox of treatment for BDP in Art Therapy is: “I am with you; but separate; I understand your need, but cannot take away your pain. To rob a patient of his anger, pain, and despair, no matter how well intentioned is to do a disservice. What Art Therapists can offer, is a holding environment, which can make pain bearable and can allow progress and growth to proceed (Rubin, 2001, p. 64).” As Art Therapists, we can model healthy attachment with boundaries and support in spite of the vacillating emotions and outbursts that clients with BDP often exhibit.

The case studies that were reviewed did create this holding environment for clients with BPD and had various techniques in doing so. The first case study is from a feminist perspective. This study suggests that a BPD diagnosis is steeped in early cultural and psychoanalytic beliefs that women with strong emotions are ‘hysterical’ faulting the mothers’ early attachment to her child creating BPD. Feminist Therapy has developed into a practice of inclusion considering culture, sexuality, gender and ethnicity within a culture. This practice empowers the client while raising feminist consciousness. The therapeutic relationship is egalitarian and power issues are discussed openly. This theory asserts that all power imbalances can be challenged when understood and that powerlessness can be transformed within the patriarchal norms of current culture. The client holds therapeutic space, by reflecting life outside the therapy space and the realities of power inequalities. While there is little research on feminism and Art therapy, Eastwood (2012) maintains that pressure to quantify and downplay the feminine, the soft, the vulnerable is a bias which comes from the moral superiority of the male cognitive style that psychologists have adopted.
Art Therapists and Feminine Theory are essentially in the same boat both are subject to inadequate theoretical and methodological tests of validity. Complex phenomena are not well suited for medical experimental research models (Eastwood, 2012). This case study is of a group of BDP women who meet for an hour and a half with 45 minutes of art making followed by a 15-minute break and a 30-minute discussion. Group members were invited to share their work with others and speak about what they wanted to. In order to get understanding of this study some of the narrative is as follows:

Karen takes this opportunity to proudly show her painting of a foot in a pink high-heeled shoe. It covers the entire page with vibrant colour. She begins to describe her desire to own such shoes and how she wishes she could leave to go shopping and buy some. The group openly show their admiration of her image and ask many question about shoes she already owns and if she can wear such high heels. The group links the image to Karen’s perceived femininity and glamour and she describes the many shoes she owns. I sense a degree of resentment in the group’s admiration of Karen’s appearance and comment on the desire and expectation of women to always be so glamorous and to be able to wear such impossible high heels (Eastwood, 2012, p. 105.)

This quote highlights the feminist theory with BPD by highlighting the pressures in our society for women to look a particular way in order to be accepted. This study valued the client’s entire story and takes into account the personal, social, economic, and political issues facing both men and women. The feminist study on BPD and Art Therapy needs to be viewed in its entirety to get a full picture of the therapeutic benefits and questions the way in which we view symptomology and assign diagnoses. This study was done in parallel with DBT and did not have any qualitative data; however, it did create a theoretical and practical group study. Limitations of this study that
are not addressed are: How do therapists deal with the intense emotional states of BPD, with therapist burn out, and maintain egalitarian client therapist relations? Further research is needed to show effectiveness of this theoretical model.

The second case study, how Art Psychotherapy is used with a client with BPD is qualitative and exploratory in nature (Lamont, Brunero, & Sutton, 2009). A non-interpretive method was used by the Art Therapist with the view that the client’s engagement with the image is therapeutic in and of itself. The therapist uses several roles simultaneously as interventions with clients. These include: being an ally to the client for insight into their own story, being a silent witness to clients to give shape to their mental image, and to facilitate a blocked client who is unable to express themselves. The therapist must also be able to demonstrate to the client that the visual communication, which is intrinsic, can throw some light on mental functioning leading to greater understanding. The client is a 46 year-old female who was admitted to the emergency room after taking an intentional overdose of prescribed medication. Staff following a similar crisis knew her. She had a long history of BPD, deliberate self-harm and extensive history of admission and engagement of mental health services. Art therapy was introduced after many other interventions had failed. Eleven sessions were documented and highlighted her ability to finally be able to express herself and her complex feelings. The following excerpt is quoted from the client of session ten:

The consumer was able to express through this image a traumatic experience that happened to her in the here and now while in the hospital. As she painted, she said: ‘I have just experienced the worst thing’. She had spent the day in ‘solitary confinement’. She painted the seclusion room with black bars to represent ‘imprisonment’, then herself as a blob of orange and black, a ring of blue around herself for ‘depression’ and the ‘arms
of God’ are protecting her in purple and gold. ‘I don’t even look like human. I look like nothing, a thing. That’s what it felt like to be thrown into that cell…I really lost it…I got really angry and out of control.’ She returned to her image and pained ‘lines of anger bursting from me.’ The angry lines became ‘my arms stretching out for someone to help me.’ She continued: ‘I didn’t think they would ever open the door. I didn’t think they would ever come to get me.’ She painted yellow fleck on her arms: ‘I still have a little bit of light in me…I felt panic, anger, and abandonment…I feel calmer about it now, I’m glad I did this.’ (Lamont, Brunero, & Sutton, 2009, p. 170)

This session highlights how this client is finally able to verbally discuss her complex emotions through the image making process. The therapeutic outcome for this particular client was she was finally able to calm herself by verbalizing her intense emotional states. This particular case though compelling needs further quantitative research on its effectiveness.

The third study found by this researcher is based on how Art Therapy can contribute to the ‘mentalization’ of BPD (Springham, Findlay, & Harris, 2012). This study defines ‘mentalization’ as a mechanism of change in the mind that occurs through psychotherapy.

This addresses the basic human capacity to apprehend our own, and others minds, or a calibration of the clients own self-perception through the understanding of others view of them. The mind looks at the mind through the lens of a psychotherapist. Mentalization-Based Treatment (MBT) was specifically developed for BPD. MBT is an approach designed to address unstable moods, identity diffusion and difficulty in interpersonal functioning. It is theorized that these difficulties are primarily due to the lack of ability to ‘mentalize; and create self-cohesion or interconnectedness. The research was conducted both with qualitative and quantitative models. The qualitative method was heuristic, naturalistic and included in depth interviews with BDP
HOW DOES ART THERAPY HELP WITH DIALECTICAL

clients. The group study was done over an 18 month period and was structured around 30 minutes of art making and optional sharing for each individual. The following sequence was followed:

- The client was invited to describe their intention for their image, what they think of it, or what they would think if it was someone else’s.
- Other clients are invited to comment or explore. If therapist doesn’t know what to say then she can state the obvious.
- Therapist invites client to focus on group feedback and describe what sense was made of it.
- The Art therapist mostly commented only after this sequence and framed comments like just another observer.
- At the end of this sequence the artists is thanked and the therapist moves to the next client (Springham et al., 2012).

After the 18 months, participants were interviewed on what Art Therapy interventions worked contributing to ‘mentalization’ and what didn’t. The results were organized into key themes in interviewing the six clients. The themes were:

- Art replaces the words clients cannot find.
- Group attention in art therapy is enhanced with a homogenous structure of clients.
- Client’s ability to accept multiple perspectives.
- Constant movement between art making and sharing artwork develops emotional regulation.
- The unresponsive therapist is counterproductive or causes harm in BDP treatment.
- At therapists watchful but not watching stance helps focus on art making.
• Art therapy can be used as self-help.

• Therapists model inquiry rather than a pre-determined knowledge to what the art is saying.

The results support how Art Therapy can help clients with BDP put words to what they feel and how it can stabilize intense moods and emotions. The results are limited to 40 participants and age and gender are not included in the study. The homogenous group is related only in that they all have a BPD diagnoses. The second part of this study is quantitative showing data before and after treatment. There was a marked improvement in distress tolerance, hospital admissions, Borderline Personality Disorder Severity, and employment status.

<table>
<thead>
<tr>
<th>Measures</th>
<th>Pre-treatment score</th>
<th>Post-treatment score</th>
</tr>
</thead>
<tbody>
<tr>
<td>BPDSI Total score</td>
<td>PT 1: 29.28</td>
<td>7.47</td>
</tr>
<tr>
<td>(0-90&gt;=20 BPD)</td>
<td>PT 2: 46.61</td>
<td>24.65</td>
</tr>
<tr>
<td></td>
<td>PT 3: 28.4</td>
<td>17</td>
</tr>
<tr>
<td></td>
<td>PT 4: 30.92</td>
<td>25.42</td>
</tr>
<tr>
<td>Distress Tolerance</td>
<td>PT 1: 1.25</td>
<td>1.6</td>
</tr>
<tr>
<td>Scale</td>
<td>PT 2: 2.29</td>
<td>3.49</td>
</tr>
<tr>
<td>(Higher Scores Higher DT)</td>
<td>PT 3: 1.79</td>
<td>3.95</td>
</tr>
<tr>
<td>Employment Status</td>
<td>PT 1: unemployed</td>
<td>Nurse training</td>
</tr>
<tr>
<td></td>
<td>PT 2: unemployed</td>
<td>Working</td>
</tr>
<tr>
<td></td>
<td>PT 3: unemployed</td>
<td>Volunteering</td>
</tr>
<tr>
<td></td>
<td>PT 4: unemployed</td>
<td>Volunteering</td>
</tr>
<tr>
<td>Hospital Admissions</td>
<td>PT 1: Admission</td>
<td>None</td>
</tr>
<tr>
<td>(Past 18 months)</td>
<td>PT 2: Contact for treatment</td>
<td>None</td>
</tr>
</tbody>
</table>
One limitation of this study is the small sample size of forty participants. Other parts of the study included a six-week period of group psycho-education, three-times weekly program compromising of one session of verbal individual, one session verbal group, and one session of group Art Therapy. It is unclear how much Art Therapy contributed to the client’s improvements (Springham, Findlay, & Harris, 2012).

Summary

Recent trends have advanced Art Therapy in a variety of ways. New neurobiology research has defined how trauma affects the brain. Trauma clients can express implicit (nonverbal) memories through art and then process explicit (verbal) in order to bring relief. Art Therapy in conjunction with bilateral stimulation is another option for trauma survivors. Art assessments used currently by artists do not have a lot of research behind it. The PPAT in one study showed it was marginally effective. More promising are the future studies for the FEATS assessment. A large data-base exists with quantifiable information to be collected for future studies. Based on a handful of studies Art Therapy may be a useful modality for those suffering from BPD. It may be of particular help with clients who have a difficult time verbalizing emotions and where other treatments have failed. Currently there are several approaches that are highlighted in what this researcher has found. A feminist approach highlights the cultural, sexual, and socio-economic issues clients may face. The BPD label might be a feminist issue since most are women. The particular study highlighted does not have any quantitative data included and is lacking in specific interventions for containment of the intense
emotionality of many BPD clients. The second case used ‘mentalization’ and integrated Art Therapy as a means to connect implicit and explicit memories with a client working through a traumatic event. The qualitative study showed improvement within the group of four but did not measure just Art Therapy; it also included Psycho-education and individual talk therapy as a total treatment. To date, there are not a lot of quantitative studies that show Art Therapies effectiveness. Further research is needed.

**Dialectical Behavioral Therapy and how it Works**

Dialectical Behavioral Therapy (DBT) is a therapy that was created for clients with Borderline Personality Disorder (BPD) and comes from a Cognitive Behavioral Therapy (CBT) model with a variety of changes. Marsha Linehan created this treatment after she noticed the high level of suicides and the lack of treatment protocol for clients after suicide stabilization. DBT is really very straightforward; it reinforces good behavior by validating rather than blaming the client and practices compassion and understanding to mitigate change. Cognitive Behavioral Therapy on the other hand, does not emphasize the validating context in treatment. Compassion, patience, and persistence are the emphasis. Behaviors are not labeled as good or bad but rather, more or less effective. The therapist believes in the client is doing the best they can and relies on efficacy of treatment (Linehan, 1993). The term ‘Dialectical’ refers to the tension between change and acceptance. The emphasis on acceptance comes from Eastern (Zen) practice and is paired with Western psychological practice. The concept is that by accepting behaviors as they are, the flow of change has already started and true change can occur. DBT focuses on process over structure and addresses core skills including: interpersonal effectiveness, distress tolerance, core mindfulness and self-managing (Linehan, 1993).
DBT is different than standard Cognitive Behavioral Models in that it focuses on acceptance validation of behaviors in the moment, emphasizes treating interfering behaviors, believes the therapeutic relationship is critical to treatment and emphasizes dialectical processes as crucial in a good DBT program (Linehan, Harned, Jackson, & Comtois, 2010). Based on Biosocial Theory DBT is a disorder of self-regulation particularly with emotions. Clients with BPD are viewed as being unusually emotional in temperament. The emotions become maladaptive by experiencing successive invalidating environments. Based on a Biosocial Model of BPD, DBT treats the development of positive self-regard as a primary goal for therapy. Clients are taught various techniques of appropriate self-evaluation, toleration of disapproval, and ways to identify degrees of self-invalidating behaviors that get in the way of targeted goals (Linehan et al., 2010).

**How Can Dialectical Behavioral Therapy Help BPD?**

Compared to Standard Cognitive Behavioral Therapy DBT is unique in that the client receives unlimited positive regard. The therapist views the client as ‘doing the best they can’ and validates the grain of truth in what they are saying producing even more acceptance from the clients point of view. How important is this bond? In a recent 2012 study that looked at the treatment differences in the Therapeutic relationship and Introject, there were some interesting findings: Introject is defined by Interpersonal Theory (Sullivan, 1953) as, parts of an individual’s personality which consist of self-directed action, cognitive self-evaluation and verbal and physical action directed towards the self. “These internal, self-directed actions are thought to be fairly stable across the life span, reflective of actions of early caregivers, and conceptually related to one’s self concept” (Bedics, Atkins, Comtois, & Linehan, 2012, p. 66).
The study reviewed looked at treatment differences in the therapeutic relationship and Introject over a two-year span. There were 101 female participants with BPD and a history of self-inflicted injury. 51 clients received DBT and 49 received care by community treatment experts. This study was a randomized controlled trial. DBT participants showed an increase of Introject affiliation through treatment and follow up. Clients reduced their self-harm behaviors regardless of their time in treatment compared to community treatment by experts (p<.02). DBT therapists were perceived by patients as emphasizing greater affirmation, protection and control during treatment (p<.04). Increased therapist affiliation associated with increased Introject affiliation in DBT (p<.03). The simultaneous use of emancipation, affirming, protecting, and controlling behavior, the DBT dialectic, predicted improved outcome in DBT (p<.05). The DBT group reported substantial increases in Introject affiliation including self-affirmation, self-love, self-protection and greater decrease in self-attack during the course of treatment and after a one year follow up compared to community treatment experts. Clients moved from a hostile, critical, and punishing Introject to overall affiliative and protective Introject that could be described as a tendency to work hard in order to take care of oneself.

One of the limitations of this study is that it did not link the therapeutic relationship directly in predicting Introject in reduction of self-harm. It did however, show significant interaction between the therapeutic relationship and treatment condition for both Introject and self-harm. This study was also based on client perceptions and reduction of self-harm behaviors. This is the first study of its kind to examine intrapsychic factors in the outcome of DBT and the first study to examine the therapeutic relationship in a randomized controlled trial of DBT. Future research is needed to study this phenomenon in more depth and with a wider range of outcomes (Bedics et al., 2012). This study suggests that the combination of tools, unlimited
HOW DOES ART THERAPY HELP WITH DIALECTICAL

positive regard, and a dialectical skills training have a significant impact on the overall wellbeing of BPD clients resulting in harm reduction. Self-harm varies from client to client with BPD but is considered a hallmark of the illness.

DBT has helped bring attention to the fact that para-suicidal behavior leads to much higher rates of suicide (Linehan et al., 2010). There have been several studies done showing DBT working for reducing the number of para-suicides and suicide attempts (Linehan et al., 1999), (Linehan et al., 2006), (Anthony, Taylor, Winmill, & Alfoadari, 2008). Para-suicide is considered nonfatal self-harm and is surrounded by controversy. Kreitmen (1977) defines it as any behavior that results in tissue damage, illness, or risk of death or ingestion of drugs or other substances not prescribed or in excess of prescription with the clear intent to cause bodily harm or death. Para-suicide includes both actual suicide attempts and self-injuring with little or no intent to cause death. Suicide is defined as self-inflicted harm to do with the intent of death, suicide threats, and almost suicidal behaviors where the individual does not complete the act. Para-suicide includes behaviors that are commonly known as suicide gestures or manipulative suicide attempts. Para-suicide is a term used to define the intent of injuries which can be to communicate, to influence others, try to commit suicide, or to regulate moods and bring relief (Kreitman, 1977). Para-suicidal behavior is a key characteristic of many with BPD. One of the issues around this definition is that a client may be viewed as just attention getting and not taken seriously. Each case needs to be carefully evaluated and great care needs to be applied case by case. It can be very easy for the mental health field to blame the victim (Linehan et al., 2010).

In a randomized controlled trial of DBT and women with BPD deliberate self-harm was measured against a control group with treatment as usual and a waiting list. There were 73 female subjects and outcomes were measured after 6 months. The reason behind the study was
ever-persistent high-risk suicidal behavior that is still a chief concern (Step, 2003). The conclusions of the study indicated that there was not a difference in deliberate self-harm compared to the treatment as usual with a waiting list. The secondary outcomes measuring disability and quality of life showed a significant effect over all with a (p. <.05) favoring DBT. This study failed to replicate some important findings that show reduction of deliberate self-harm over a 6 month period, although there was improvement over time in both groups. The study suggests that maybe it was too short in length. Other studies of this kind were 12 to 18 months in length (Batemen, 1999; Linehan, Armstrong, Allman, & Heard, 1991). Treatment was preferred for complex BPD in a study which looked at BPD clients who were suicidal, self-injuring and who had PTSD. Since many with BPD have PTSD, up to 58 percent (Jackson, Comtois, & Linehan, 2012), they are considered more impaired in a variety of areas than those with either disorder alone. There were 42 women participants ranging from 19-57 years in age and had suicidal behavior within 2 to 3 months in the study. The majority of women (73%) preferred to receive DBT and Prolonged Exposure Therapy together; 26% preferred DBT alone and no participants indicated a preference for Prolonged Exposure Therapy alone. The most common reason underlying treatment preference was to obtain relief from distress (32%). Those who showed preference for DBT alone expressed concerns for Prolonged Exposure Therapy. Women who preferred a combined DBT and Prolonged Exposure Therapy were more likely to report wanting relief from distress, particularly trauma related distress.

This is the first investigative study done on preference among individuals with BPD and PTSD. The findings indicate that the majority of these clients prefer a DBT and Prolonged Exposure Therapy to help them obtain relief from BPD, PTSD and general distress. The problem is that clients are unlikely to be able to access the treatment they prefer because Prolonged
Exposure Therapy is commonly not recommended for BPD clients. The concern is that it will do harm with severe BPD clients. There has been research that both can be applied in a safe effective matter (Jackson, Comtois, & Linehan, 2012).

**Can DBT Help With PTSD?**

The correlation between a diagnosis of BPD and history of trauma is well documented (Golier et al., 2003). DBT uses exposure-based procedures informally throughout treatment to expose clients to aversive emotional states. In DBT, standard exposure procedures are used and modified. Modifications include targeting emotions such as guilt, shame, and anger. In the DBT model select strategies and skills are used in treating dissociative behavior common in clients with trauma. Dissociation is the avoidance of aversive internal or external stimuli. By using a chain analysis of the sequence of events before and after the behavior, the therapist can use strategies such as emotion regulation, cognitive restructuring, and exposure to aversive emotions. The first goal in the treatment of dissociative behavior is to reduce the availability of cues to traumatic experiences that lead to dissociative behavior. This includes avoiding discussion of trauma until Stage 2 of DBT treatment and avoiding current traumatic environments using distress tolerance skills. The second goal is to regulate emotional responses to traumatic cues and emotions. DBT accomplishes this goal through teaching mindfulness and emotion regulation skills and exposure to present emotions and traumatic experiences. Finally, the third goal is to change the value of the cue linked to traumatic experiences. Formal exposure procedures used in DBT Stage 2 treatment are used to change these associations (Mulick, Landes, & Kanter, 2005).

In a pilot study by Iverson, Shenk, & Fruzzetti, (2009) DBT was used for victims of domestic abuse. Thirty-one women showed a significant reduction in depressive symptoms, hopelessness, and general psychiatric distress as well and increased social adjustment. At pre-
treatment assessment, nearly 25% met the criteria for high suicidal assessment. After treatment only 7% met criteria for high suicidal risk. Similarly, at pretreatment, the participants’ average social adjustment score was nearly two Standard Deviations above the community sample mean (lower scores show better adjustment). Post-treatment the group was nearly two SDs below community mean. Part of the success may be the self-validation skills because they may have difficulty labeling and expressing their emotional experiences accurately and assertively as a consequence of invalidation. Accurate expression is self-validating. Mindfulness and self-validation skills also may be useful for increasing awareness of danger-related cues, reducing the likelihood of future victimization.

One limitation of the study was that it was only 12 weeks in duration. Another limitation was that there was no control group indicating whether treatment gains were truly reflective of specific treatment components or other nonspecific factors such as group cohesion, and/or positive alliances. DBT would be beneficial and viable since it can be done in a group setting, lowering the cost for women in shelters or with little income (Iverson, Shenk, & Fruzzetti, 2009). Individuals with PTSD have been found to be at higher risk for both suicidal behavior and non-suicidal self-injury. The U.S. National Comorbidity Survey found that individuals with PTSD were six times more likely to attempt suicide and five times more likely to report suicidal ideation than those without PTSD (Kessler, 2000). Even with the higher rates of PTSD clients at risk for suicide and self-harm, it is common practice to exclude individuals with co-occurring disorders from PTSD treatments. PTSD practice guidelines from the International Society for Traumatic Stress studies recommend that, “If significant suicidality is present, it must be addressed before any other treatment is initiated” (Foa, Friedman, Cohen, & Cohen, 2009, p. 9). That is where DBT can come into play. Since it was already designed to deal with Suicide and
para-suicide, there is evidence that it can help with PTSD with suicidal or para-suicidal behaviors.

Details in a study that used DBT as a precursor to PTSD treatment for self-injuring and or suicidal women included 51 participants with BPD and 26 participants who met the criteria for PTSD. Borderline Personality Disorder clients with and without PTSD were equally likely to eliminate exclusionary symptoms preventing them access to PTSD treatment. By post treatment 50-60% of BPD clients with PTSD would be suitable candidates for PTSD treatment. BPD clients with PTSD who began treatment with a greater number of recent suicide attempts and more severe PTSD were significantly less likely to become eligible for PTSD treatment. A case can be made that DBT can be an alternative or a precursor to those suffering from PTSD or where clients to not qualify for Prolonged Exposure Therapy (Safia, Jackson, Comtois, & Linnehan, 2010).

**Summary**

Dialectical Behavioral Therapy was designed by Marsha Linehan and based in Biosocial Theory. It was designed specifically for BPD with high suicide risk. DBT is different than Cognitive Behavioral Therapy in that it reinforces good behavior and is validating, rather than blaming. The term ‘Dialectical’ refers to tension between change and acceptance. Based on the biosocial model, client maladaptive behavior comes from invalidating environments. DBT can help with self-directed action, cognitive self-evaluation and verbal and physical action directed towards self (Introject). The therapeutic bond leads to less self-inflicted injury and more self-love, self-protection, and self-affirmation. Clients moved from hostile, and punishing Introject to overall affiliative and protective Introject. Self-harm is considered the hallmark of BPD. Para-suicide includes actual attempts at self-injuring with little or no intent to cause death.
Para-suicide is a term used to define the intent of injuries that can be, to communicate, to influence others, to commit suicide, or to regulate moods and bring relief. Suicide is defined as self-inflicted harm with the intent of death. In one study (Safia et al., 2010), DBT did not show significant difference in lower deliberate self-harm compared to controls, but did show improvement in disability and quality of life. As far as what BPD clients who self-injure and who have PTSD, the majority preferred DBT and Prolonged Exposure therapy in combination. The studies viewed are recent cases on the effectiveness of DBT for BPD clients. The findings suggest that BPD helps with Introject, and reduces self-harming behaviors.

Dialectical Behavioral Therapy uses exposure-based procedures informally throughout treatment to expose clients to aversive emotional states. The first stage of DBT focuses on reducing traumatic cues. The second stage focuses on exposure procedures. In a pilot study (Iverson et al., 2009) that used DBT for victims of domestic abuse, 31 women showed a significant reduction in depressive symptoms, hopelessness, and general psychiatric distress as well as increased social adjustment. At pre-treatment nearly 25% met the criteria for high suicidal assessment. Post treatment only 7% met criteria for high suicide risk. Success may be in part, because DBT is self-validating and helped with the labeling and expressing emotions accurately. Individuals with PTSD have been found to be at higher risk for both suicidal behavior and non-suicidal self-injuring. Prolonged Exposure Therapy can only be initiated if there isn’t significant suicidality present in PTSD. It is not uncommon for PTSD treatment to be excluded with co-occurring disorders present. This is exactly why Marsha Linehan developed DBT; there was no treatment available to help with suicide and para-suicide. In a study of DBT for Borderline Personality Disorder and PTSD post-treatment resulted in a 50-60% increase in clients’ suitability for PTSD treatment. There is scant research on the effectiveness of treating
PTSD with DBT but there is definitely data to suggest it could be used as a precursor to PTSD with BPD clients.

**PTSD and Neurobiology**

How the brain processes trauma is important in understanding many of the symptoms that occur with trauma and the need for new treatments that will make the client feel safe, understood and have a more positive sense of self in order be treated effectively. Often times the client does not realize that he/she is suffering from trauma or Post Traumatic Stress because of how the brain can process trauma. Understanding the neurobiological effects of trauma are helpful in understanding the long-term effects clients may have (Tummala-Narra, Kallivayalil, Singer, & Andreini, 2012).

Surviving trauma is not a conscious event that happens in the frontal lobes rather it is a primitive survival response that happens in temporal lobes and the limbic system. The limbic system stores emotions, senses, and relational experiences (Vermetten & Bremmer, 2002). The chain of events during a traumatic experience, are primal, instant, and efficient to optimize survival. First the amygdala picks up a threat using all 5 senses, and then the thalamus engages and sends the sensory information back to the amygdala and prefrontal cortex. If the threat or alarm is real the information is then transferred to the hypothalamus to engage the sympathetic nervous system where neurochemicals from the adrenal glands start the adrenaline stress response. As our survival response prepares to “fight or flee”, the thalamus causes an increase in heart rate, respiration, and pupil dilation. All non-essential systems are turned off, including the frontal cortex containing the hippocampus. The hippocampus is in charge of recall and mediating memory function and defines the importance of the event. This survival mode shuts down the ability to bear witness to the event or the entire experience. As we prepare to “fight or flee”, the
adrenal glands initiate the reciprocal activity in the parasympathetic system (Fisher, Para. 5). Problems occur when integration of the memory does not occur and are divided into 3 main categories, re-experiencing of past traumatic events, avoidance of stimulus, and persistent symptoms of increased arousal. The client becomes sensitive to stress fear. At which point the client may not be able to stop the process (Vermetten & Bremmer, 2002). In some cases where the victim cannot escape the traumatic event, a “freeze” can occur. After the event the hippocampus is not able to put the experience into chronological order or make sense of the event. The hippocampus is not able to process the events that are usually processed during sleep. This is why many children experiencing ongoing stress from abuse may have memory loss.

There are particular problems when the victim is a child and abused by a caregiver. Children are biologically wired to seek closeness to a parent or caregiver for safety. If the parent is the abuser it creates a double bind, the very person who should protect them hurts them, and this can lead to disorganized attachment. The child may demonstrate ambivalent truncated responses to the person providing care. The child may physically turn toward a parent, stop, freeze, and often have a glazed or frightened look. The attachment to the parent can be intensified as is the fight or flee response. This disorganized attachment may complicate all future relationships including therapists in therapy. Over time this behavior may become familiar, habitual, and many times lifelong. The symptoms may define who they are, and as adults they cannot fully remember or put words to their experiences or history (Fisher, 2003).

The symptoms that may develop from attempting to cope with trauma are: self-injury, suicide, risk taking, re-enacting behavior, caretaking, self-sacrifice, re-victimization, and addictive behavior. All of these symptoms represent different ways of modulating a dysregulated nervous systems. Self-injury and suicide release adrenaline and endorphins; self -
starvation and overeating result in bio-chemicals that cause numbing. Addictive behavior can be tailored to induce numbing or increased arousal and/or a combination of both (Vermetten & Bremmer, 2002)(Fisher, 2003).

**Traumas impact on the Community**

Trauma has impacted all of us even if we are not aware. From crime to self-harm our society as a whole suffers without treatment for the traumatized. It is estimated that in the United States, 1 in 3 women and 1 in 5 men have experienced sexual abuse as children. Statistics show that between 2,000 and 5,000 American children die annually from physical abuse. Many trauma victims are now sitting in jails and mental hospitals with no treatment or help for recovery. Abuse is culturally a taboo topic and many do not speak up do to shame or retribution. At times, when the abuse is disclosed, they may not be believed or suffer humiliation. The cycle of abuse continues in families because of the silence and secrecy (Main State Dept. of Behavioral and Developmental Services, 2001).

**Trauma Statistics**

- “50% to 70% of all women and a substantial number of men treated in psychiatric settings have histories of sexual or physical abuse, or both.

- As high as 81% of men and women in psychiatric hospitals with a variety of major mental illness diagnoses, have experienced physical and/or sexual abuse. 67% of these men and women were abused as children.
• Women molested as children are 4 times more at risk for Major Depression as those with no such history. They are significantly more likely to develop bulimia and chronic PTSD.

• Childhood abuse can result in adult experience of shame, flashbacks, nightmares, severe anxiety, depression, alcohol, and drug use, feelings of humiliation and unworthiness, ugliness and profound terror.

• 97% of mentally ill homeless women have experienced severe physical and/or sexual abuse. 87% experienced this abuse both as children and as adults.

• The majority of adults diagnosed with Borderline Personality Disorder (81%), or Dissociative Identity Disorder (91%) were sexually and/or physically abused as children.”

(Main State Dept. of Behavioral and Developmental Services, 2001, p. 3.)

Trauma is a pervasive problem and currently the research is beginning to find better ways of treating and providing access for much needed services.

Developmental Trauma

Developmental trauma was proposed in the DSM-V in hopes of getting young victims the help they need as well as to give adults who have suffered from childhood trauma the validity of ongoing symptoms that started from childhood trauma. These diagnoses would pinpoint the difficulties as a result of early onset trauma to a child. This would include children and youth who exhibit characteristics as a result of exposure to early, chronic, and severe traumas. With
complex trauma there are several comorbid diagnoses that do not fit with early traumatization (Van der Kolk & Pynoos, 2009). Children with developmental trauma may experience abandonment, sexual abuse/assault, emotional abuse, and/or witnessing of violence or death. Particular problems arise when the young victim has no escape route and the caregiver is the one who is the perpetrator. These types of repeated events can cause problems with attachment, authority, lack of impulse control over emotions and cognitive and attention deficits. Some pharmacological approaches are used with attention deficit disorder, cognitive behavioral problems and antisocial behaviors. Van der Kolk believes that approaching results of abuse as a separate diagnosis is treating symptoms rather than a trauma disorder (Van der Kolk & Pynoos, 2009).

**Complex Trauma**

Complex Post Traumatic Stress Disorder (C-PTSD) is not formally recognized as a diagnostic system currently in the DSM-IV. Many mainstream journals recognize this type of stress and it is defined by a psychological injury that results from extended exposure to persistent social or interpersonal trauma with lack or loss of control, disempowerment, and in the setting of captivity or entrapment, and a lack of a feasible escape route for the victim.

PTSD does not capture this type of stress because it primarily is derived from observations of relatively circumscribed events and does not capture the prolonged repeated trauma of a victim. The focus of PTSD alone has hindered the study of the variety of trauma responses and does not take into account the course of stress disorders. Complex Post Traumatic Stress Disorder has not been represented by the American Psychiatric Association or World Health Organizations despite the long-term intensive effort to include it by researchers and clinicians alike. One reason Vedat says is because of the comorbidity covering several varieties
of psychopathology and the theoretical nature of DSM classifications prevent C-PTSD from being recognized as a separate diagnostic category (Vedat, 2011). Many clients with C-PTSD share early life stressors in the form of developmental trauma alongside a diagnoses of BPD, Somatoform, dissociative, mood, eating, and substance abuse disorders. This is where the impasse is thought to occur according to Vedat (2011). Although not considered as an alternative to PTSD, Borderline Personality Disorders have been increasingly linked to developmental traumas (Vedat, 2011). A traumatized individual may develop Borderline Personality Disorder as well as other Axis I and II disorders depending on the onset, length of time, and severity (Vander Kolk & McFarlane, 2007). Implications for childhood sexual abuse for adult BPD and C-PTSD study showed that 65% women met criteria for early onset abuse and late onset abuse. The diagnoses for both BPD and C-PTSD were significantly higher in women reporting early onset abuse than those with late onset abuse. The trauma variables were sexual abuse and paternal incest and were significant predictors of both diagnoses. In contrast with those suffering with comorbid diagnoses, some women with a history of childhood sexual abuse may be removed from the diagnoses of BPD and re-diagnosed under that of C-PTSD (McLean & Gallop, 2003).

It is evident in this study the overlap of Borderline Personality Disorder and Post Traumatic Stress Disorder Symptoms.

**Post-Traumatic Stress Disorder**

Post-Traumatic Stress Disorder (PTSD) can occur after one sees or experiences a traumatic event that involves threat of injury or death to self or someone else. The event can also be a natural disaster, war, terrorism, rape, prison stay, domestic abuse and/or assault. For those suffering from PTSD there are certain criteria that must be met. In 2000 the American Psychiatric Association revised the PTSD diagnostic criteria in the fourth edition of its
Diagnostic and Statistical Manual of Mental Disorders. “Diagnostic criteria for PTSD include a history of exposure to a traumatic event meeting two criteria and symptoms from each of three symptom clusters: intrusive recollections, avoidant/numbing symptoms, and hyper-arousal symptoms. A fifth criterion concerns duration of symptoms and a sixth assesses functioning (American Psychiatric Association, 2000 p. 429.) Post Traumatic Stress Disorder as outlined in the DSM IV accurately describes a client who has experienced a short-lived trauma. Some examples may include: natural disasters, car accidents, and rape. Chronic traumas may continue or repeat for months or years at a time (Cloiter et al., 2009).

Many clinicians and researchers have found that the current PTSD diagnosis often does not capture the severe psychological harm that happens with such persistent, repeated trauma. Healthy people who experience chronic trauma can experience ups and downs in their self-concept and the way they adjust to stressful events (Whealin & Slone, 2007). DSM-IV Field Trials indicated that 92% of individuals with Complex PTSD/DESNOS also met criteria for PTSD. Based on these trials, Complex PTSD was not added as a diagnosis (Cloiter et al., 2009). Exposure to multiple traumas, particularly in childhood, has been proposed to result in a complex of symptoms that includes PTSD as well as a limited, but variable group of symptoms that emphasize self-regulatory disruptions.

The relationship between accumulated exposure to different types of traumatic events and total number of different types of symptoms (symptom complexity) was assessed in an adult clinical sample (N = 582) and a child clinical sample (N = 152). Childhood cumulative trauma but not adulthood trauma predicted increasing symptom complexity in adults. Cumulative trauma predicted increasing symptom complexity in the child sample. Results suggest that Complex PTSD symptoms occur in both adult and child samples in a
principled, rule-governed way and that childhood experiences significantly influenced adult symptoms (Cloiter et al., 2009, p. 1).

Clients with a history of trauma rarely experience a single traumatic event but are more likely to experience several incidents of exposure to trauma. Frequent reports among survivors of childhood abuse, domestic violence, and those who have been witnesses to or targets of genocide, have described this type of trauma. Sustained, repeated or multiple traumas especially in the childhood years, is thought to produce more complex symptomology than posttraumatic stress symptoms alone (Cloiter et al., 2009). The current standard of diagnosing trauma in the DSM-IV-TR does not currently allow variations of the disorder. The limited diagnoses can impede efforts to conceptualize this disorder over a lifetime and minimize the complexity and far reaching damage it may cause. Kardner (2007) theorized stages of trauma. The first stage is the core traumatic response (What is now diagnosed as PTSD). The second stage is the personality’s adaptation to reorganize compromised functioning. “This includes PTSD and its variants; dissociative disorders; brief reactive psychosis and other disorders directly related to the traumatic stressor; comorbid diagnoses with either a primary or a secondary relation to the stressor; and issues such as delayed intermittent, or recurrent forms of the disorder (Van Der Kolk & McFarlane, 2007, p. 125).” The danger lies in the fact that the DSM only deals with the first stage and can be prematurely dismissed by clinicians. There are many reactions to trauma and more research is needed to understand the pathology it may take as a result. The definitions of trauma are changing as researchers learn more about the far-reaching effects of trauma both on the mind and the body.
What Is Borderline Personality Disorder and How it Affects the Community

Borderline Personality Disorder is characterized by symptoms of severe mood disturbance, impulsive behaviors, inappropriate anger, self-harm behaviors, relationship problems, and identity disturbances. In the DSM-IV-TR it is diagnosed with 5 of the following 9 symptoms:

1. Frantic efforts to avoid real or imagined abandonment.
2. A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation.
3. Identity disturbance: Markedly and persistently unstable self-image or sense of self.
4. Impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating).
5. Recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior
6. Affective instability due to marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days)
7. Chronic feelings of emptiness
8. Inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights).
9. Transient, stress-related paranoid ideation or severe dissociative symptoms.

(American Psychiatric Association, 2000, p. 710)

There are considerable variations of the course of BPD. The most common is a chronic pattern of instability, in early adulthood with episodes of serious emotional fluctuation and lack of impulse control. Clients with BPD usually use mental health resources at a high rate.
The impairment from the disorder and risk of suicide are greatest in the young-adult years and lessen with advancing age. Intense emotions, impulsivity, and intense relationships usually are a life-long occurrence. Clients who engage in therapeutic intervention often show improvement during the first year. During their 30s and 40s the majority with BPD will achieve greater stability in their relationships and work functioning. Follow up studies from mental health clinics indicate that after 10 years, as many as half of the clients will no longer meet the full criteria for BPD.

Some associated features of this disorder include: undermining themselves at the moment a goal is about to be realized, Psychotic like features, premature death from suicide, self-inflicted abuse behaviors, recurrent job losses, interrupted education, broken marriages and a history of sexual abuse, neglect, hostile conflict, and early parental loss or separation. The common co-occurring Axis I disorders include Mood disorders, Substance related disorders, eating disorders, PTSD, and Attention-Deficit/Hyperactivity Disorder. BPD also frequently co-occurs with other Personality Disorders. Clients with BPD are very sensitive to environmental circumstances and make frantic efforts to avoid real or imagined abandonment. They may have a great fear of being alone. Their frantic efforts to avoid abandonment may include impulsive actions such as self-mutilating or suicidal behaviors. They may idealize potential care-givers or lovers at first or second meeting and demand to spend a lot of time together and share the most intimate details early in a relationship and then switch quickly to devaluing them, feeling the other person does not care enough. They can be nurturing and have empathy as long as the person will be there to meet their own needs on demand.

Many BPD clients have an unstable sense of self. They may switch dramatically in goals, values, and vocational careers. Many times they feel bad, evil, or that they do not exist at all.
Individuals with BPD display impulsivity in at least two areas that are self-damaging. Examples are gambling, spending money irresponsibly, binge eat, abuse substances, engage in unsafe sex, and driving recklessly. Suicide threats and attempts are very common. Recurrent suicidality is many time the reason for use of mental health services. Separation or rejection or expectations that they assume increased responsibility will often precipitate these destructive acts. Self-mutilation may occur during dissociative experiences and often bring relief by reaffirming the ability to feel or by atoning the individual’s sense of being evil.

Mood reactivity can be extreme. The basic dysphoric mood is often disrupted by periods of anger, panic, or despair and is rarely relieved by periods of well-being or satisfaction. These episodes may reflect on the client’s extreme reactivity to interpersonal stresses. Many experience chronic feelings of emptiness, are easily bored, and frequently express inappropriate intense anger when a loved one is viewed as being neglectful, withholding, uncaring, or abandoning. During extreme stress, transient paranoid ideation or dissociative symptoms may occur. Usually this does not last long and does not warrant additional diagnosis. The real or perceived return of the care-givers nurturance may result in a remission of symptoms (American Psychiatric Association [DSM-IV-TR], 2000).

Marsha Linehan describes BPD as clients with third degree burns over most their body and relates this to the emotional agony that BPD clients struggle with (Linehan et al., 1999). One of the hallmarks of BPD is intentional self-harm acts and suicide attempts. 70%-75% of BPD clients have a history of at least one self-injurious act (Clarkin, Frances, Hurt, & Gilmore, 1983). These self-harm acts range from small acts such as slight scratches, head banging, cigarette burns, and light skin cutting to more serious acts such as overdoses, asphyxiation, and self-stabbing. Suicidal behavior can be to help cope with pain or can be a real attempt at suicide.
Higher suicide rates with BPD clients have been well documented. A 2003 study looked at all paper reviews research from Medline and Psych INFO data bases between 1984-2000 containing key words “borderline personality disorder” and “suicide” or “suicidality”. A total of 170 articles were reviewed and found that 1 in 10 BPD clients actually commit suicide. Paris noted also that chronic suicidal behavior could be best described as a way of communicating extreme distress (Paris, 2002).

**History of Borderline Personality Disorder**

Borderline Personality Disorder was a new addition to the DSM-III in 1980, classified on axis II in diagnostic manual’s new multiaxial system. Classifying personality disorders on a separate axis came about from the widely shared belief, continuing into the 1980s, that these disorders were psychogenic, caused during early development by parental neglect, abuse or inconsistency. Clients with BPD were described as showing social contrariness and as consistently using others for one’s own end. The hallmark of this illness at the time included traits such as anger, volatility, prone to reject help, blaming others, and behaving self destructively. Many clinicians at the time believed that this behavior was willfully oppositional. BPD clients were spoken of as dreaded pariahs. Usually recommended therapy was psychodynamic psychotherapy or psychoanalysis that was uncertain and proved to have poor prognosis (Oldham, 2009).

The name Borderline Personality does not come without controversy, it was first used by Adolf Stern in 1938 described a group of outpatients who did not profit from classical psychoanalysis and who did not fit into the neurotic or psychotic categories. Psychopathology at that time was conceptualized on a continuum from normal to neurotic to psychotic. Stern labeled his group of outpatients as suffering from a borderline group of neuroses. For many years after,
the term was used among psychoanalysis to describe clients who, although had severe problems in functioning, did not fit into other diagnostic categories and were difficult to treat with conventional analytic methods. In recent years, the understanding of BPD has been labeled and described as being eclectic and descriptive. The defining characteristics have largely been defined on consensus, although empirical data are finally now being used to some extent to refine definitions. Even in the DSM-IV, the methods of selecting are not made clear and appear to be based on clinical criteria rather than empirical evidence. The criteria are defined by consensus of committees formed by the American Psychiatric Associations and based on the combined theoretical orientations of the committee members, data on how psychiatrists in practice use the term, and empirical data collected to date. The official terminology and diagnostic criteria have been chosen through political compromise and current empirical data. This points to theory still being involved with diagnosing and treating BPD today (Linehan et al., 1999).

**Borderline Personality Disorder Statistics**

In recent years interest in BPD has increased due to the flooding of BPD clients in mental health facilities and clinicians offices. Eleven percent of all psychiatric clients and 19% of psychiatric inpatients are estimated to meet criteria for BPD. Out of all the personality disorders BPD is 63% more likely to be inpatient, and 30% outpatient. Another reason for the interest is available treatment modalities appear to be woefully inadequate. Follow up studies suggest that initial dysfunction of these clients are often extreme, clinical improvement slow, improvement may be marginal for many years after assessment. BPD clients are so numerous that most clinicians will have to treat at least one. The clients present with severe problems and intense misery and are very difficult to treat successfully. Many clinicians feel overwhelmed and
inadequate, and are in search of treatments that promise relief for their clients (Linehan et al., 1999). Other statistics:

- BPD is highly stigmatized in the world.
- Many clinicians refuse to treat BPD.
- Decreased glucose uptake in medial orbital cortex may be associated with diminished regulation of impulsive behavior in BPD.
- Most experts today agree that BPD is on the wrong Axis code. Instead of axis I I it should be on Axis 1 of the DSM.
- 50% experience clinical depression.
- Diagnosed more often in females, up to 75%.
- Most clinicians are either mis-educated or under-educated about BPD and appropriate treatment.
- Successful suicide rate doubles with a history of self-destructive behaviors and suicide attempts.
- Treatable with medication initially and psychodynamic therapy complimented with Dialectical Behavioral Therapy (DBT). Many doctors in the field do not recommend therapy without proper medications.
- BPD is virtually unknown to the public.
- On Minnesota Multiphasic Personality Inventory (MMPI), BPD clients do not show a common profile. Personality traits appear to be a combination of histrionic, narcissistic, antisocial personality.
- Of dual diagnosed clients, 50-65% have BPD.
• Approximately 25% of clients with BPD also meet the criteria of Post-Traumatic Stress Disorder (PTSD).

• Discontinuation of medications is as high as 50%.

69%-75% exhibit self-destructive behaviors such as self-mutilation, chemical dependency, eating disorders, and suicide attempts ("BPD today," n.d.).

• Childhood abuse and neglect are common with up to 87% suffering from some sort of abuse (Perry & Herman, 1993)

Evidence-based therapies do exist but need wider dissemination. About 85% of people with BPD also meet the diagnostic criteria for another mental disorder. A medical profile of a woman in her 30s is typical of a woman in her 60s. Economically 40% of the high users of mental health services are BPD clients and 50% are severely impaired in employability. 17% of the prison population is implicated in BPD. Lastly 38% of those with BPD have substance abuse/dependence disorders. Growing awareness, treatments, research, and education are bringing BPD along slowly. In 2006 NAMI raised BPD to one of its priority populations ("BPD today," n.d.).

**PTSD and BPD and the Controversy**

The term Borderline Personality Disorder surrounds controversy. Since the disorder is Conceptually and phenomenologically similar to Posttraumatic Stress Disorder a term complex PTSD would it has been argued, be both more accurate and less stigmatizing (Gunderson & Sabo, 1993). BPD was diagnosed as a personality disorder based on the works of Kernberg. Borderline Personality Organization (BPO) was a psychodynamic concept that was characterized by identity diffusion that derived from lack of integration between early positive and negative object relation experiences. BPD is among many disorders that can derive from impairment of
three core internal psychological processes of BPO that are: identity diffusion, primitive defenses and intact reality testing. BPO is theorized to represent the common assumption underlying personality disorders today (Kernberg, 1967).

Little has been changed in the DSM regarding BPD whereas PTSD has undergone a lot of changes. The modern conception of PTSD showed up in the DSM III in 1980. This was driven to capture the symptoms experienced by Vietnam veterans and World War I “Shell Shock” soldiers. The DSM-IV PTSD diagnoses have been subject to important alterations. The nature of what establishes a stressor was most debated in DSM criteria A. Current versions have expanded the boundaries of what a qualifying stressor consists of. The biggest controversy of PTSD has been whether it should be in the DSM at all. Prominent authors in the field argued that the disorder was in part, socially constructed.

BPD as defined by the current DSM-IV-TR has been referred to as a, nebulous diagnoses because of the extensive overlap with other mental disorders. Attempts at reclassifying BPD into Schizophrenia Spectrum Disorder, Impulse Spectrum Disorders, and Affective Illness Disorder have not helped in understanding etiological and theoretical diagnoses of BPD. The most influential reclassification has been on the trauma spectrum and proposes adding Complex PTSD as a reclassification. Complex PTSD has gained momentum and has offered insight and alternate treatment interventions. The literature on childhood trauma and the diagnoses of BPD is immense and at times inconclusive. Many studies report a high rate of child abuse in BPD as high as 81%-91% have suffered from some sort of childhood abuse or neglect; most notable is the high rate of sexual abuse. The rate of comorbid PTSD with BPD clients is as high as 58% and above 10% of the population (Lewis & Grenyer, 2009). Herman and van der Kolk observed that both disorders share similarities in five areas: affect regulation, impulse control, reality
testing, interpersonal relationships, and self-integration. In affect regulation disturbances both disorders share depression, intense anger, irritability, and chronic feeling of emptiness. In impulse control, both share substance abuse and self-destructive behavior. In reality testing, both have paranoid ideation and dissociation. Interpersonal relationships include intense attachment issues, and withdrawal of them. Lastly under self-integration, identity diffusion and sense of inner badness can be both present in BPD and PTSD (Herman & Van Der Kolk, 1987). From a more feminist perspective Hodges has pointed out that the reason women are seven times more likely than men to receive a BPD diagnoses because culturally they have been viewed as hysterical, problematic, and have flawed personalities. Hodges points to research showing women being much more likely to be sexually abused than men and suggests the label of BPD can blame the victim and may not focus on the impact of PTSD stressors (Hodges, 2003).

Is BPD Really Complex Trauma?

The relationship between BPD and traumatic events are well documented in research. Depending on what study, the high rate of early trauma often overlaps BPD and range from 26%-57% (Zanarini et al., 1998; Hudziak et al., 1996). Childhood trauma is common in BPD clients. In a study of 180 outpatient participants with personality disorders 41% reported a history of physical abuse, 26% reported history of sexual abuse, and at the majority had at least one traumatic event before 18. This particular study did not single out BPD from other personality disorders. One of the weaknesses of this study was that 65% of the participants were male, which is not representative of the BPD population with 75% being female (Golier et al., 2003).

Theoretically BPD has had a variety of views weigh in on the cause. Some authors emphasize the importance of genetic personality traits and their role of risk protection in regard
to context sensitivity, some have related early attachment relationships with symptomology, while others point to a higher prevalence of severe chronic trauma particularly early in life, and lastly some believe it is really Complex Trauma that is misdiagnosed as BPD (Gonzales, Mosquera, & Van Der Hart, n.d.). The current research on clients with BPD and PTSD is varying and inconclusive yet, there is strong evidence that the symptomology has marked similarities. In a ten-year course of PTSD in borderline clients and axis II comparison subjects the lifetime prevalence of PTSD is 7 times as likely in the general US population. With sexual abuse in particular, only half of the clients had remission from PTSD (Zanarinir et al., 2011).

In regards to suicide attempts, severity of sexual abuse predicted the number of suicide attempts in a 2-year follow up study (Links, Kolla, Guimond, & McMain, 2013). The role of sexual abuse in particular raises new possibilities in classifying and assessing clients presenting with BPD symptoms. PTSD is a diagnosis given to clients presenting with symptoms reflecting childhood sexual abuse. These symptoms include intrusive imagery, dissociative episodes, self-mutilative behavior, psychological numbing, and physiological arousal. They overlap with Borderline symptomology. Given the extent to which they overlap, it is possible that the characterological traits may result from particularly harsh experiences of abuse, or abuse that occurred for prolonged periods of time or was accompanied by other complicating factors that made the abusive situation more difficult for the victim. Basically, BPD may be the most severe manifestation of severe abuse experiences. All too frequently clients presenting with these symptoms are diagnosed with BPD leading to inappropriate treatment approaches and the placement of a negative label on the clients (Berez, Morrison, Schumacher, & Coffey, 2011).

This raises the question as to the tension between these two diagnoses. What makes a borderline a true borderline? Judith Herman has found through many years of research on trauma
that post-traumatic stress can become chronic and integrated into the victim’s personality structure (Herman, 1986). How do the symptoms actually compare? To answer this, Berez points to themes that are descriptive in both. The first persistent theme is a particular cognitive style, marked by “poorly focused thinking, self-rumination, transient dissociative stated, disorganized under stress and the use of impulsive action to short-circuit unpleasant mental states. The second is an emotional intensity or lability which is felt by the patient as overwhelming (Berez et al., 2011, p. 396).” With self-mutilating behaviors, clients with complex sexual trauma issues may self-injure to avoid thoughts or feelings about a traumatic event and use this means as a nonverbal expression of distress, to obtain relief from chronic feelings of emptiness, depersonalization, and unreality. The reason for self-mutilating behaviors also can be a means for expressing feelings of responsibility for the occurrence of sexual abuse. Dissociation with depersonalization can occur with what Kinsbury (1988) found with clients to be psychogenic amnesia, emotional numbing, and avoidance during repetitive and intrusive imagery of past events.

In a study about the role of childhood sexual trauma in the symptomology of BPD clients, 67 women were recruited from newspapers, radio, advertisements and local community mental health centers. Accepted participants had to have at least one lifetime suicidal event and had to be post discharge from a mental health facility. All tests were two-tailed in with x set at .05. The results showed that symptom severity but not BPD symptom severity were significantly related to emotion dysregulation. The greater the level of PTSD symptom severity, the greater negative affect intensity and affective lability. PTSD symptom clusters may correspond to distinct deficits in emotion regulation, such that re-experiencing/hyperarousal symptoms may be relevant to emotion under-modulation. This study shows that severity of abuse can impact BPD
characteristics as well as clients being diagnosed improperly resulting in poorer treatment options. Side by side analysis of symptoms BPD and PTSD do not completely address the conditions of clients with sexual abuse histories. Current treatments and diagnoses can either help or exacerbate symptoms with clients who continue to suffer from long term effects of early complex sexual abuse (Landecker, 1992). The research is clear on the symptoms of complex developmental sexual trauma but how it fits exactly into the DSM is unclear. The first order of our helping profession is to do no harm. And to that end more research is needed.

**Current Trends and Possibilities**

This researcher noticed a shift in what causes BPD while researching this paper. In going to various BPD websites, emphasis has been placed on heredity being a large part of the diagnoses of BPD ("BPD today," n.d.). This year a longitudinal discordant twin study was conducted with 756 twin pairs from an 11 year old cohort and 626 pairs from a 17-year old cohort. Birth records and public databases were used to locate more than 90% of the families in Minnesota from 1972-1974. Final assessment was measured at 24 years old. Impulsivity and inability to inhibit externalize (EXT) and Predisposition to experience depression anger and anxiety (INT) were measured against childhood abuse (CA) and the genes of monozygote (MZ) and dizygote (DZ). The results indicated that genetic influences better accounted for BPD symptoms than child abuse (Bornovalova et al., 2013).

This large study has carried a lot of weight in the BPD community. One of the biggest problems with this study in the researcher’s view is that it is based on self-report of sexual abuse. Shame and disgust often stop women from reporting or even talking about childhood sexual trauma (Rahm, Rench, & Ringsberg, 2006). After long-term abuse, amnesia, inability to verbalize, and organize what happened may not be possible for a victim. Neurobiological finding
on how the brain adapts under trauma is also a large factor in under reporting of abuse. It is possible that even at 24-years, participants weren’t ready to verbally share or possibly remember the occurrence of traumatic events. The other possibility is that parents transmit their genotype to their offspring as well as help create the rearing environment, creating a genetic predisposition to impulsivity aggression or negative emotionality in both. These conditions set up a more likely scenario for hostile and abusive family environments. In light of this new research, a new layer of complexity has been added to the already complex symptomology of abuse and the link with BPD traits. The cultural significance for the DSM is also at stake. Medication is the luxury of mood disorders that promises recovery, BPD on the other hand has been labeled a Personality Disorder leading researchers away from finding medications that work and blaming the victim is a real possibility. A BPD diagnoses is viewed in clinical settings as a illness no one wants to touch yet a PTSD diagnoses offers more care and support from providers and creates the validating environment that help the abused heal. The issues are complex and more research is needed to help abused victims who exhibit BPD traits.

**Summary**

Neuroscience shows how trauma can effect memory integration, memory loss, and the ability to make sense of the traumatic event. Trauma impacts society as a whole and abuse is culturally a taboo subject. 50%-70% of all women and a number of men treated in psychiatric settings have histories of sexual or physical abuse or both. Developmental trauma gives adults who have suffered childhood trauma validity and a way of understanding ongoing psychological effects they experience. Complex-Trauma is developmental trauma with another diagnoses such as BPD. Post-Traumatic Stress can be diagnosed with one exposure or experience of a traumatic event. Many researchers/clinicians have found that a PTSD diagnoses alone does not capture the
extent of psychological harm done. More research is needed to understand the trauma process and how it affects children and adults over time.

Borderline Personality Disorder is typically a chronic pattern of instability early in adulthood with episodes of serious emotional fluctuations and lack of impulse control. BPD clients use a high rate of mental health resources and are not often easily treatable. Suicide attempts and self-harm behavior are common and usually the hallmark of the illness. Adolf Stern first used the word Borderline Personality in diagnosing clients who did not fit into neurotic or psychotic categories and did not respond well to conventional analytic methods. The diagnoses itself has controversy.

The methods used in the DSM are not made clear and appear to be generally based on clinical criteria rather than empirical evidence alone. BPD clients present with severe problems and intense misery and clinicians feel overwhelmed and inadequate to give relief. Many clinicians will not see BPD clients for that reason. BPD clients are hard to diagnose and often show other personality traits. Many BPD clients have dual diagnosis, which also complicate care. Growing awareness and research is helping with better treatments but BPD is still in need of more research and funding to help those who intensely suffer.

Depending on what study reviewed the relationship between trauma and BPD has been well documented. Theoretical findings suggest genetics, early attachment, and trauma exposure are the cause of BPD and developmental trauma, emphasizing early sexual abuse. Symptoms may completely overlap but depending on the diagnoses may cause great distress in the clients recovery. PTSD is treated within a trauma survivor mindset whereas BPD is treated as a difficult illness many clinicians do not want to treat. A misdiagnosis can actually harm clients who suffer from severe BPD symptomology correlating with severity of complex trauma histories. In 2013,
a new longitudinal study found direct correlation with genetic predisposition rather than childhood abuse as being most predictive of a BPD diagnoses. BPD websites have moved away from a trauma emphasis to a genetic emphasis being most important in BPD etiology. The complexity of research, cultural bias, and DSM prognosis still do not fully assess the relationship between PTSD and BPD in treatment options for recovery.

**Final Summary**

In recent years neuroscience has allowed clinicians and scientists alike in understanding how trauma impacts the brain. As a result, understanding of implicit and explicit memory and how it plays out in traumatic events is becoming more understood. Art Therapy may help put words to the memories that are not accessible to verbal understanding. Art can capture the fleeting emotional messages that then can be realized in a therapeutic environment. EMDR using bilateral image making may help. More research is needed in this area but in current case studies it has been effective. FEATS and PPAT may further give clues to the Art Therapist as to the nature of trauma helping the therapeutic alliance. Art Therapy may help with BPD as well although there is very little research to back it. The clients art may clarify and connect worlds of language and image in understanding outer reality. A feminist approach to Art Therapy focuses on the power of inequalities of current power structures and creates a validating environment that has shown to be helpful in treating BPD. Art Therapy can also help BPD clients in mentalization of unstable moods, identity confusion, and interpersonal chaos. Art Therapy may be able to stabilize and calm intense moods and emotions.

Studies have shown that DBT may help BPD clients that are higher risk of suicide suggesting a severe trauma exposure link. In current clinical practice significant suicidality must be addressed before any other treatment is initiated. DBT was designed by Marsha Linehan to
target suicidal and para-suicidal behavior. The treatment is a variant of DBT and validates the
responses of BPD behaviors. DBT is the only psychotherapy treatment to date that has helped
borderline symptoms. Because many BPD clients also have PTSD it is plausible that
neurobiological underpinnings of BPD point to a dysregulated nervous system creating a primal
response that occurs in the temporal lobes and out of the range of consciousness causing various
coping responses. Symptomology resulting from clients trying to regulate this system range from
self-injury to addictive behavior. This may be one reason why BPD is considered the great
imitator of other illnesses.

The impact of trauma on the community is great. Up to 81% of men and women in
psychiatric hospitals with severe mental illness have experienced abuse. 67% were abused as
children. Women who are molested as children are 4 times more at risk for major depression,
bulimia, and or PTSD. Trauma definitions are still not clearly delineated for those suffering from
developmental and complex trauma. PTSD is a limiting diagnosis for complex trauma. Current
PTSD guidelines came into the DSM by way of traumatic war effects. Currently war veterans
have taken precedence in research and treatments. Current language used to define PTSD best
describes war like traumatic effects. Many clinicians and experts believe that PTSD as outlined
in the DSM-IV does not address the far-reaching damage it causes in developmental or complex
traumas, especially childhood sexual abuse.

Borderline Personality Disorder has historically had many controversies and is a
relatively new DSM diagnoses. BPD showed up in the DSM III in 1980. Clients were mostly
women and were stigmatized and clinically described as selfish and self-serving, manipulative,
self-destructive, volatile, irresponsible, and refusing of help. Clinicians believed that this willful
and oppositional behavior was purposeful. BPD clients became a pariah to the mental health
HOW DOES ART THERAPY HELP WITH DIALECTICAL

community. Very little improvement was found in this population and there was not enough research or new therapy interventions available at the time. Matters were complicated in a political and cultural climate that viewed most of these women as attention seeking and a drain on mental health resources. In the last 10 years things have changed drastically due to more neurobiological research studies describing how BPD actually progresses.

With the high rate of dual diagnoses with BPD, controversies on what BPD really is have been hotly debated. The only real theoretical view that gained traction was that BPD was really PTSD, more succinctly complex developmental trauma. Van Der Kolk and other pioneers in the field have presented research and compelling evidence that BPD symptoms can be a result of developmental trauma. This created a paradigm shift in how BPD was viewed since its inception into the DSM in 1980. This researcher found symptomology of both illnesses to be interchangeable around themes and symptoms. Recent trends this year have changed BPD community and professional websites to emphasize the genetic predisposition to BPD that exists even in measuring child abuse histories. This researcher hopes that the pendulum doesn’t swing back to having a BPD diagnoses becoming more stigmatizing like it started out in the 80’s. In conclusion, it is quite evident that diagnosing early trauma, especially sexual trauma, needs to be carefully considered before a clinician gives a diagnoses of BPD. In the mean time more research is needed on how to treat developmental and complex traumas suffered in childhood and its long lasting effects on sufferers.
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HOW DOES ART THERAPY HELP WITH DIALECTICAL


HOW DOES ART THERAPY HELP WITH DIALECTICAL

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Adlerian view of Trauma

The Adlerian views trauma in terms of finding out what a client’s private logic is. Many times clients who suffer from trauma are very removed from the history or even the events themselves. As collaborators with a client who suffers trust, rapport, and safety are very therapeutic. Doing a thorough history and timeline would help to see the gaps in a suffering client and help them see possible memory lapses. Early recollections with these clients would be very helpful in seeing some of the mistaken beliefs they may have picked up during traumatic times in their lives. Art Therapy could help in a recreation of early recollections and possibly reframing the events in a more constructive effective manor.

If insight is difficult, Art Therapy may help with painful memories or thoughts and integrated into a shift or perception of mistaken beliefs and possibly where they came from. Creating a safe place where the client can go would help them stop when the feelings become overwhelming.

Adlerian believe in encouragement and the building of self-esteem. Unconditional positive regard and reframing problems to challenges for a client with trauma would help them move from victim to survivor. Helping the client see their faulty logic and reframing the trauma may evaluate current beliefs about shame, guilt, and helplessness.
All people need to belong and have courage to make changes in thoughts, purpose, and actions. Taking responsibility for these steps will help the client with self-esteem, caring about others, and contributing to society.