THE DIALECTICS OF EFFECTIVE TREATMENT OF BORDERLINE PERSONALITY DISORDER

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The universe is so constructed that the opposite of a true statement is a false statement, but the opposite of a profound truth is usually another profound truth.

N. Bohr, cited in *The Spectrum of Consciousness*

In this chapter we describe the theoretical bases of dialectical behavioral therapy (DBT). DBT was originally developed to treat suicidal behaviors (Linehan, 1987), was expanded to treat borderline personality disorder (BPD; Linehan, 1993a, 1993b), and is currently being expanded once again to treat substance abusers (Linehan, 1993c). To our knowledge, however, the only empirical investigations of the treatment have been with chronically suicidal BPD clients (Barley et al., 1993; Linehan, Armstrong, Suarez, Allmon, & Heard, 1991; Linehan & Heard, 1993; Linehan, Heard, & Armstrong, 1993; Linehan, Tutek, & Heard, 1992). These studies have demonstrated the effectiveness of DBT when compared with standard "treatment as usual" in the community. As the treatment's name suggests, the concepts of synthesis and integration are important in DBT. The treatment evolved from a tension between an emphasis on change, typical of behavior therapy interventions, and an emphasis on radical acceptance of
the client “in the moment,” which is seen by Linehan as a requisite stance for treating severely impaired individuals. Although the concept of acceptance is ubiquitous in psychotherapy, the strategies of acceptance in DBT were drawn primarily from Western client-centered approaches (e.g., Rogers & Truax, 1967) and Eastern philosophies, particularly Zen philosophy and practice. The tension inherent in the opposition of acceptance versus change, which Linehan proposed as the core tension in psychotherapy, required a theoretical framework that could both accommodate and ultimately synthesize opposing views. A dialectical theoretical and philosophical position provided such a framework.

The focus in this chapter is on describing the dialectical bases of the treatment. Although the principles of both learning and of Zen practice are extremely important to understanding and applying DBT, we describe them only briefly here. As noted by Heard and Linehan (1994) and described more fully by Linehan (1993a), the behavioral theory underlying DBT is closest to the psychological behaviorism advocated by Staats (1975). Similar to Staats’s approach, the biosocial theory of borderline personality disorder offered by Linehan integrates basic theories of emotion and temperament (Cacioppo, Klein, Bernston, & Hatfield, 1993; Derryberry & Rothbart, 1984, 1988; Ekman, Levenson, & Friesen, 1983; Eliaz, 1985; Izard, Kagan, & Zajonc, 1984; Izard & Kobak, 1991; Kagan & Snidman, 1991; Malatesta, 1990; McGuire, 1993; Strelau, 1985), cognitive and social learning theories (e.g., Bernhard & Teasdale, 1991), as well as principles of operant and classical conditioning. The integration of Zen within DBT is described in Heard and Linehan (1994) and is not discussed here. The astute reader, however, will note that the dialectical principles of interrelatedness and change are similar to the emphasis on unity and impermanence in Zen; the dialectical notion of opposition can be compared to the “harmony of empty oneness and the world of particulars” (p. 143), which is the definition of Zen given by Zen master Robert Aitken (1982).

DIALECTICS

Dialectics has been referred to as the logic of process. Most often associated with Marx and Marxist socioeconomic principles, the philosophy of dialectics actually dates back thousands of years (Bopp & Weeks, 1984; Kaminstein, 1987). Hegel is generally credited with reviving and elaborating the dialectical position. He discerned that specific forms or arguments come and go in a complex interplay, with each argument creating its own contradiction, and each contradiction in turn being negated by a synthesis that often included or enlarged on both preceding arguments, beginning the entire process anew. What remains consistent, and thus becomes worthy of study and philosophical explication, is the process of change. Hegel
wrote that “appearance is the process of arising and being and passing away again, a process that itself does not arise and pass away, but is per se, and constitutes reality and the life-movement of truth” (cited in Weiss, 1974, p. 8). As such, “the truth of the process is not to be found in any of its single phases, but in its totality (which is no mere plurality), the rational rhythm of the organic whole” (cited in Weiss, 1974, p. 8).

Dialectics has been offered as a coherent system of exploring and understanding the world (Basseches, 1984; Kaminstein, 1987; Levins & Lewontin, 1985; Riegel, 1975; Wells, 1972) and has been given often as an alternative to the classificatory logic found in traditional science. After all, “real life operates dialectically, not critically” (Berman, 1981, p. 23). Hegelian dialectics is the philosophy of movement, of processes unfolding in time, and of the interactions among phenomena that make up the beginning, middle, and end of any process. An extensive discussion of dialectical philosophy (in its various incarnations) may be found in Wells (1972) and Reese (1993). A few paragraphs here would not do the philosophy justice, but they are necessary to flesh out the developmental background of DBT and to provide a rationale for some of its tactics and goals.

The Philosophy of Dialectics

One difficulty in presenting the viewpoint of dialectics is the inherent contradiction between a dynamic philosophy and a linear form of communication. Hegel pointed out that within each beginning is necessarily found an endpoint, for the beginning is posited only on the assumption of some process that is unfolding toward an end; there is no beginning without an explicit reference to a process and conclusion. Thus, each beginning also contains its own endpoint and also includes the potential for developing toward that endpoint. Conversely, each endpoint contains its own beginning and developmental history.

A beginning, Hegel will say, in the sense of something primary and underived, not only makes an assumption but is an assumption, and its fate is to be abolished as such. Any proper, self-respecting beginning, he holds, suffers this fate at its own hands, its negation being the result of an immanent dialectic that abhors the vacuous abstraction of immediacy and converts its promise into a performance. (Weiss, 1974, p. 3)

The process whereby a phenomenon is transformed is the dialectic, which essentially is a three-stage process. The first stage is the beginning (which, of course, is essentially indivisible from the ending). It is the initial proposition, a positive statement, an affirmation (e.g., “life has meaning and possibility”). The second stage involves the negation of the beginning phenomenon and is therefore the contradiction of the initial proposition.
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two are indivisible within the dialectical reasoning.) Levins and Lewontin (1985, p. 278) pointed out that the consideration of phenomena as heterogeneously composed has important implications for scientific inquiry. The fact that parts are not merely diverse but are actually in contradiction or opposition to one another focuses the observer not on a taxonomical identification of the parts but on the relationship or interaction of the two as they move toward resolution. Also, the fact that wholes comprise heterogeneous parts argues that “there is no basement,” no fundamental unit or particle. What is fundamental is the pattern of relationship.

Second, the parts acquire properties only as a result of being identified as parts of a particular whole. Thus, the same part may have much different qualities or properties if viewed as an aspect of different wholes. Of course, parts of different wholes will embody different contradictions and dialectical syntheses. Third, parts and wholes are interrelations, not mere collisions of objects with fixed properties and immutable boundaries. As such, the parts cannot participate in creating the whole without being simultaneously affected themselves by the whole. Thus, we argue, for instance, that it is not possible for the inpatients of a particular mental health center not to somehow alter the system within which they interact (and which would not exist without them), and it is certainly the case that they will simultaneously be affected by the system.

Fourth, as mentioned already, dialectics recognizes that change is an aspect of all systems and is present at all levels of a system. Stability is the rare occurrence, not the idealized goal. However, as Levins and Lewontin (1985, pp. 274–282) pointed out, dialectics should not be viewed as some dynamic balance or homeostatic environment; it is neither the careful balance of opposing forces nor the melding of two open currents. Rather, dialectics involves the complex interplay of opposing forces. The white yin and black yang of Eastern philosophies do not combine to form a tepid, gray mush but continue to oppose one another, surging here and receding there as they respond to both internal and external forces. Equilibrium among forces, when found, is discovered at a higher level of observation, namely, by looking at the overall process of affirming, negating, and the formation of a new, more inclusive synthesis of the two (Basseches, 1984, pp. 57–59). What is stable is the continued interplay of forces; there can be no final domination. Thus, change is not the superficial pattern masking some underlying stability; it is the underlying dance of the world, and stasis is one's own imposition of convenience based on societal values (Levins & Lewontin, 1985, p. 275).

Finally, it would be helpful to examine the root metaphors of dialectics to see how they might relate to the therapeutic process and to DBT in particular. As discussed by Reese (1993), dialectical materialism has its base in the concept of praxis. Although this term has different levels of meaning, the sense common to all of them is “a concrete, goal-directed
act being performed by a human being in a concrete situation at a specific time" (Reese, 1993, p. 72). Praxis is thus the linchpin of dialectical materialism, the central element on which analyses rest. The “energy” in dialectical materialism, the force that ultimately drives the creation and synthesis of opposites, is the efforts of humans to enforce change in their world (see Reese, 1993, for an extended discussion of this). Although some may recoil at this distinctly anthropocentric viewpoint, it is perhaps refreshing to others to note the acknowledgment of human activity inherent in people’s understanding of the world around them (see Jaeger & Rosnow, 1988). By contrast, the process of struggle and unity of opposites in dialectical idealism is energized by the universal truth bursting forth in manifold ways. In some way the universe itself is driving the process, delighting in its display of manifest truth (dialectical change). DBT moves back and forth between the two views, using human activity as a motivator in some instances (e.g., pointing out the contradiction between the cultural ideals created and upheld by humans and actual body types of individuals) and larger, natural contradictions in others (e.g., the interplay of chance and skill in the outcome of human interventions). Although the philosophy of dialectical materialism relevant to DBT (corresponding to behavioral theory as a foundation of DBT) views humans as imposing an order on an uncaring world, dialectical idealism (corresponding to the roots of DBT in Zen psychology) believes that people can recognize and experience a unity and pattern inherent in the organization of the universe.

The definition of praxis as human activity unfolding toward a specific goal within a given context is one that naturally lends itself to the therapeutic environment. It contributes both a focus for therapeutic inquiry (behavioral analysis) and a structure for contemplating knowledge and truth (the effectiveness of behavior). Praxis is the fulcrum that supports theory or belief on one end and reality or context on the other; people’s theories about how the world works are continually being put to the test in their attempts to modify or effect change within it. Experience gained during one’s efforts may then be used to modify knowledge and thus to inform future interventions. Of course, just as one cannot step into the same stream twice, dialectics would acknowledge that people interact with a constantly changing world, albeit one that may have some consistency. Dialectical analysis of actions and theories encourages people to stay awake, to continue to review their beliefs about the world that fuel their interventions, and to remain open to the impact of their actions and to feedback from the environment. Humans are encouraged to engage the world and simultaneously observe its response and effects on them, with their natural inclinations being to maximize the success of their actions.

Therapeutically, the application of behavioral principles to a given client requires just such open experimentation. A basic example is in con-
structing a contingency plan for behaviors exhibited by the client. Reinforcers and punishers are not universal phenomena. Praise may be either reinforcing or punishing to an individual (see Emotional Vulnerability Versus Self-Invalidation section for the DBT caution concerning praise with BPD individuals), and thus the therapist must be aware of the response of the client, including whether the behavior that the therapist praised occurs more or less frequently in the future, and rely less on his or her own assumptions about whether a given behavior is reinforcing.

Before proceeding, two caveats are important. First, dialectics is an attempt to study movement and change by using a language that has been shaped assuming the fundamental stability of nature. Deitz (1986) discussed the influence of "mental idioms," common words that do not always mean what they seem to mean. Particularly relevant to our discussion is the section devoted to nouns that masquerade as "person, place, or thing." Some of these nouns are the "heuristic concepts" noted in frustration by Bateson (1979), including notables such as patience, length, and even mind. Other nouns are those that, to paraphrase Skinner, "find, or seem to find, things where there are only actions" (cited in Deitz, 1986, p. 163). Of course, Skinner could not phrase the sentence without using one of the nouns that he criticized; action, like activity, is the noun form of an event occurring in real time. What we are attempting to capture through the noun is the movement of one acting, movement that is much more "sensible" in the gerund form (i.e., one has more of a sense of movement when one is discussing "acting" rather than discussing a discrete "act"). In essence, people's language has turned many of their processes into static entities, and these in turn shape their thought to attend to completed events rather than the flowing stream of activity and interaction of forces.

Second, we discuss briefly the issue of dialectics as opposed to other ways of viewing the world. It is important to recognize that arguments between proponents of differing worldviews are, in essence, "illegitimate" and nonresolvable (Hayes, Hayes, & Reese, 1988). Causal and dialectical logic are, in and of themselves, differing worldviews (Wells, 1972). Thus, although both levels of examination may be appropriate when answering different questions, those who are inclined to argue the merits of one system over the other are doomed from the start. Not only is it senseless to use the values of one to criticize another, but to point out the shortcomings of one worldview does nothing to strengthen the position of the second (Hayes et al., 1988). Linehan advocates dialectics because the viewpoint has been extremely helpful in directing treatment with specific populations, and because, as she and her colleagues have devoted more of their efforts to observing "process," they have come to new realizations concerning DBT itself and new ways of looking at therapy in general.
Although not the foundation of a formal school of thought within psychology, dialectical methods and inquiry have found a small following. Dialectics has shaped the thinking of articles in topic areas as diverse as development (Basseches, 1984; Riegel, 1975), cognitive development (Kramer & Melchior, 1990), interpersonal communication and creativity (Spitzberg, 1993; Thompson, 1991), and organizational behavior (Schwenk, 1990). We have already pointed out that dialectics have been theoretically tied to contextualism (Reese, 1993), which is itself the root metaphor underlying the application of radical behavioral techniques to therapy (see Hayes, 1987).

Within cognitive developmental theory, Basseches (1984) and Kramer and Melchior (1990) proposed that dialectical thinking is the final stage of cognitive development, superceding Piaget’s stage of formal operations. Whereas formal operational thought enables a thinker to deal with closed systems as wholes, those authors proposed that dialectical thinking enables one to organize the interactions of multiple systems over time and thus engages one in thinking about the nature of systems rather than about the nature of parts in one system. Kramer and Melchior (1990) wrote that a number of cognitive developmental psychologists have now recognized this ability, placing the rudiments of dialectical thinking in adolescence. Furthermore, they noted that females tend to develop dialectical thinking several years earlier than males, perhaps because of the necessity of balancing conflicting role options and demands during adolescent decision-making. These results would seem to indicate that therapy with BPD clients, who appear to demonstrate a marked deficiency in dialectical thinking, should include specific strategies to foster more dialectical approaches to viewing the world and interacting with it. DBT does both.

Dialectics and BPD

DBT is based on a biosocial theory that assumes that BPD is the outcome of a transaction between an individual with a constitutional vulnerability to emotion dysregulation and an environment that is prone to invalidate the expression of private experiences, beliefs, and actions (Linehan, 1993a). In contrast to theories such as the stress–diathesis model (which posits that an inherent debilitating factor resides within the individual, awaiting activation by events within the environment), DBT suggests that the individual and the environment are developmentally coactive in providing conditions for the development of dysfunction. On the one hand, the individual “elicits” the environment that creates dysfunction, and, on the other hand, the environment exacerbates vulnerabilities.
that, in a more benign environment, might not have developed. In the first case, the individual eliciting the invalidating environment, the theory is similar to Millon's (Millon & Everly, 1985) biosocial learning theory of personality disorders, wherein childhood biological substrates lead to behaviors that elicit particular classes of response from caretakers and begin to establish patterns of interaction that later "crystallize" into personality.

Linehan (1987, 1993a) posited that BPD individuals have a biological predisposition toward emotional dysregulation. As such, emotional responses to environmental stimuli occur more quickly, are more intense, and have a slower return to baseline than responses of non-BPD individuals. This creates the potential for an individual who will not only respond strongly, but one who may be inclined to display increasingly intense levels of responding attributable to continued environmental input before return to baseline has occurred, creating a vicious feedback cycle. As such, babies who are easily subject to overstimulation may withdraw more readily from close contact initiated by their parents, a tendency that is not likely to reinforce parents who are seeking closeness or responsiveness. This withdrawal may prompt a response from the parents, such as intensified efforts to attract the infant or perhaps giving the infant less attention. Either response will elicit yet another response from the infant, until a pattern of interaction begins to emerge that more or less consistently characterizes the relations of the family constellation. (See Scarr & McCartney, 1983, for a further discussion of this point.)

The invalidating environment is one in which actions and communication of private experiences are met by erratic, inappropriate, extreme responses. The fundamental message sent to the individual is that his or her typical responses to events are invalid, incorrect, or inaccurate. In such environments, verbal expressions are not taken as accurate descriptions of private experience. Both verbal and nonverbal expressions and actions are not taken as valid responses to events; are punished, trivialized, dismissed, or disregarded; or are attributed to socially unacceptable characteristics such as overreactivity, inability to see things realistically, lack of motivation, motivation to harm or manipulate, lack of discipline, or failure to adopt a positive (or, conversely, discriminating) attitude. In such environments, escalation of emotional displays or communication efforts are frequently met by erratic, intermittent reinforcement. Restrictions are often placed on the type and degree of demand that the person can put on the environment. The invalidating environment typically produces a need for extreme behaviors in order to have problems recognized. The end result of such an environment for those who are highly responsive and who are not taught emotion coping skills (because problems are essentially denied) is that extreme emotional outbursts may become adaptive behaviors.
Dialectical Dilemmas

Along with the primary dialectic between the emotionally dysregulated individual and the invalidating environment, Linehan (1987, 1993a) proposed three additional dialectical patterns of behavior frequently observed among BPD individuals. All three are not necessarily issues for every person meeting criteria for BPD, but, on the basis of clinical observation, they seem to be typical of the group as a whole.\(^1\) These patterns may be represented as polar positions on three major axes: emotional vulnerability versus self-invalidation, unrelenting crisis versus inhibited grieving, and active passivity versus apparent competence. Neither end is inherently dysfunctional; rather, it is the rapid or wide swings between the two that typifies the borderline individual's process. Although most individuals will recognize these dialectical dilemmas as representative of their own behaviors at certain points in their lives, it is the inability of the BPD individuals to synthesize the poles and transcend the dichotomy that typifies their behavior. BPD individuals are seemingly fixed at a level of observation that is bound too tightly; they are neither able to break free from their vacillations between opposing positions nor are they able to enlarge their contextual framework to allow for a synthesis and resolution of the two poles.

Emotional Vulnerability Versus Self-Invalidation

The term *emotional vulnerability* refers to the extreme sensitivity to emotional arousal and susceptibility to negative emotions, together with the individual's awareness or experience of this vulnerability. Linehan (1993a) hypothesized that individuals with BPD have emotional responses to environmental stimuli that occur more quickly, are more intense, and have a slower return to baseline than the responses of non-BPD individuals. There are consequences of this vulnerability and to the individual's awareness and experience of it. First, emotions are postulated to be primary to experience (e.g., Zajonc, 1984) and are entire-system responses, which is to say that an emotion cannot be separated from the processes of cognition or physiology; it is instead, the substrate or medium within which these systems operate (Malatesta, 1990; see also Smith & Lazarus, 1990). Individuals with BPD often appear to experience difficulty regulating the entire pattern of responses that accompany a particular emotional state (Linehan, 1993a). As such, people with BPD are the prototypical examples of the James-Lange (James, 1884; Lange, 1885) theory of emotion, finding themselves running away from the bear before they have realized that they are

\(^1\)DBT encourages practitioners to assess each client individually before drawing any conclusions concerning characteristic patterns of behavior. In this way, it is more similar to the "discovery-oriented philosophy" of science advocated by Follette, Houts, and Hayes (1992) than the medical model advocated by taxonomic categorization of behavior.
fearful. Thus, they may not be able to interrupt obsessive ruminations or block escape behaviors commonly associated with fear. Although Zajonc (1984) would argue that all emotions precede people's cognitive appraisal of a situation, Smith and Lazarus (1990) pointed out that cognitive activity is exceedingly important to their experience of any given emotion. Specifically,

more complicated species have to stake their security on the capacity to evaluate the significance of what is happening. . . . However, because there is no simple mapping between objective stimulus properties and adaptive significance, the task of detecting significant events becomes quite formidable, and to accomplish it the organism must be able to somehow classify what is being confronted into a relatively small number of categories, corresponding to the various kinds of harm or benefit it may face. Above all, the emotional response is not a reaction to a stimulus, but to an organism (person)-environment relationship. (Smith & Lazarus, 1990, p. 614)

Thus, Smith and Lazarus (1990) linked emotional experiencing to a biological substrate in dialectical engagement with cognitive processes, which are in turn shaped by sociocultural learning. Individuals with BPD may find themselves at a disadvantage in all three areas, given that they may have disruption in both biological (reactivity) and cognitive (memory, cognitive development) systems that are further compounded by the poorness of fit with their family system.

In addition to difficulties in regulating emotions, intense emotional arousal interferes with other ongoing behavioral responses. As a result, the most carefully laid plans or well-rehearsed response may be beyond reach as emotional response levels rise. Furthermore, the unpredictable onset and inability to control intense emotional reactions lead to a sense of loss of control and unpredictability about the self. This is not to say that there are not times when control is possible but that the prediction of those times is uncertain. Finally, this sense of being out of control leads to specific fears that increase emotional vulnerability even more. For instance, fears of novel situations or situations in which the individual is out of control are increased, and such situations are either strictly avoided or met with intense efforts to assert control. As such, an entire range of experiences (novel situations) is missed with their concomitant broadening of experience or extension of competencies. Similarly, outcomes that might have been possible were the individual not attempting to dominate the flow of events are blocked off; positive events and outcomes are limited, and negative outcomes that are based on repetition of previously ineffective strategies are increased. Such experiences inevitably would seem to increase one's sense of vulnerability.

In addition to the fear of situations in which there is loss of control, individuals with BPD also demonstrate intense fears surrounding the ex-
pectations of individuals with whom they have significant relationships (Linehan, 1993a). The reason is simple: An inability to predict under what circumstances they will perform well leads them to question when they will be able to meet expectations. Additionally, individuals with BPD often have a history of disappointing others who have expected things that they are incapable of delivering (e.g., being unable to simply smile through pain and ignore their emotional discomfort). As such, praise from significant others may be associated with a history of increased expectations, and therefore they may elicit a negative reaction from individuals with BPD. Praise in these instances comes to be associated with expectations that the individual can perform the praised behavior in different situations or at different times. The pairing of praise with expectations, and the subsequent pain of not meeting those expectations, creates an aversion to praise in some BPD individuals and a situation that may increase suffering as they scramble to undo the praise or, conversely, to exceed their current capabilities and please the friend or family member.

At the other end of this dialectic is self-invalidation. Self-invalida
tion is the adoption by individuals with BPD of the attitudes and characteristics of the invalidating environment. This adoption means that these individuals will tend to mistrust their own perceptions of reality and thus lose some sense of their individual identities. Although one might easily imagine such a loss of self occurring in extreme circumstances (such as “brainwashing” prisoners of war), the radical behavioral view of “self”-development easily explains such a process. In fact, given the total domination of family over the activities and socialization of some children, it is difficult to imagine how children subjected to such invalidation could help but adopt the prevailing attitudes.

The radical behaviorist view claims that identity, or “self,” is a product of one’s verbal community and is learned as the “constant” that is referred to by others seeking one’s point of view; it is the “you” in sentences and questions addressed to a child (see Kohlenberg & Tsai, 1991). It is fostered through parental (or other) attention to minute changes in behavior on the part of the child and correct labeling of what the new behavior may represent in terms of the child’s internal state. For instance, irritability may be caused by fatigue, hunger, or a host of other conditions. Correct identification of the cause of discomfort and communication of this to the child increases the child’s ability to identify and report on his or her own internal states. Lack of consistent identification and validation of that viewpoint may therefore interfere with the development of a consistent sense of identity.

Theoretically, there may be multiple adverse consequences of being raised in an invalidating environment (Linehan, 1993a). First, given the enormous pressure to mask negative emotions, a BPD individual’s conscious
experience of them may be greatly curtailed. Along with this, the ability to recognize and label emotions appropriately is left undeveloped, leaving individuals confused and unable to validate their own emotional experiences or those of others. Third, individuals do not learn to trust their own emotional experiences as valid reflections of individual and situational events. Furthermore, if, as often happens in invalidating environments, communication of negative emotions is punished, then a secondary reaction of guilt and shame begins to be associated with the initial experience of negative emotions, further increasing the avoidance of experiencing them in the first place. In response to such an environment, the individual will need to escalate the intensity of his or her emotional responses or the presentation of environmental circumstances to be validated. Such individuals may also learn to scan the environment for cues of what is appropriate behavior. Both are adaptive measures in a world in which emotions are experienced as highly intrusive, yet something to be feared.

A fourth consequence of living in an invalidating environment may be that individuals learn to apply the behavior change tactics of the environment to themselves. As such, they tend to set unrealistic goals for behavior for themselves and to punish themselves for not attaining their goals, ignoring the possible incremental changes in responding by which they may have progressed. The powerful principles of shaping are never learned; individuals may find themselves trapped in a vicious cycle of attempting to interact with their environments while being unsure of their ability to respond, setting goals that far exceed their capabilities, and inevitably failing to live up to those goals. Furthermore, such individuals may miss behaviors representing approximations toward their goals, thereby failing to profit from any positive increments of change in effectiveness of their behavior that may be built on in responding to future similar situations. Despondency or desperation increase, with concordant emotional reaction and lowering of ability to respond nonemotionally, and the rollercoaster continues.

It is important to note the interconnection of the two ends of the dialectic. Dialectics allow for the juxtaposition of any two aspects of being (in this case, behaviors) that are relevant (see Reese, 1993). This is to say that there must be some intrinsic connection between the two ends of the dialectic and some meaningful movement between the two ends that can end in synthesis and the concurrent creation of a new dialectic that incorporates elements of the prior thesis and antithesis. The dialectic of emotional vulnerability versus self-invalidation may be seen as the substrate of experience that necessarily colors the rest of the BPD individual's life. As noted by Malatesta (1990), "emotions or moods act as selective filters on the world, controlling perception and hence one's interpretation of reality" (p. 10). Furthermore,
although basic emotional programs appear to be hard-wired into the mammalian nervous system . . . humans, and possibly other primates, are capable of exerting instrumental control over the behavioral expression of emotion. Most commonly this control takes the form of intensifying or deintensifying the basic emotional expression or qualifying it in some way. (Malatesta, 1990, p. 16, italics added)

For individuals with BPD, the experience of attempting to control their emotions has been largely through adopting the environmental biases of denial and invalidation. Such strategies are not only ineffective but may be damaging to the development of what may be considered the second most primary experience, that of self. It is along this continuum from domination by emotional reactivity to domination of environmental control that the individual with BDP moves. It is at this level that interventions must be directed if he or she is to address the dialectic and allow a synthesis to emerge.

Linehan (1993a) noted that the dialectical dilemma for individuals with BPD lies between accepting the environmental evaluations placed on them (i.e., they are able to control their emotional responses, and they are bad or evil for not doing so) and accepting their own subjective experience (i.e., they have little control over their own emotional responses and the world is inherently unfair for subjecting them to such trials). A closely related dilemma revolves on whom to blame for their situation, the environment that makes them feel bad or themselves for their apparent lack of control over their own emotions and experiences. Assisting the client to achieve some synthesis between the two positions also places the therapist in the dilemma of whether to validate the pain of the client (and thus be seen as not attempting to help) or induce change in the client (and thereby invalidate the pain the client is experiencing or overestimate the client’s abilities, re-creating his or her environment of origin). Resolution of the therapist’s dilemma involves swift movement from validating pain to confronting the client’s interpretations and suggesting constructive change. Change is necessary because the pain is so intense.

Active Passivity Versus Apparent Competence

“Active passivity” describes the tendency on the part of the patient to approach problems passively, demanding that the environment or persons in the environment offer solutions. Thus, the individual is actively expecting that others solve the problem instead of actively attempting a solution himself or herself. Such behaviors have also been noticed in “high monitors” of medical research (Miller & Mangan, 1983). The learned helplessness model of learning (Seligman, 1975) may help to describe the etiology of some of this behavior. Individuals with BPD often vacillate be-
between the classical learned helplessness of passive apathy and giving up versus active (albeit often indirect) attempts to elicit help from the environment. Given a history of inability to meet behavioral demands of the social environment despite one's best efforts, and an environment in which coping strategies are neither taught nor recognized as necessary steps toward the behaviors demanded, the individual is left in a no-win situation of being asked to respond appropriately without being taught how. The properties of active passivity have been documented in hospitalized parasuicide patients (Linehan, Camper, Chiles, Strosahl, & Shearin, 1987) and have been noted by other researchers to be corollaries of BPD (Perry & Cooper, 1985).

The term apparent competence (Linehan, 1987, 1993a) refers to the tendency of individuals with BPD to appear to observers to be more emotionally and behaviorally competent than they in fact are. Such apparent competency is a result of two distinct patterns. First, people with BPD often display effective and appropriate behaviors in a given situation, yet they behave remarkably inappropriately or claim no knowledge of what is appropriate in (seemingly, to the observer) similar situations. For instance, individuals with BPD may demonstrate very good skills in assisting others, but they may not necessarily be able to apply the same skills to similar situations in their own lives. Unfortunately for such people, apparent competence works against them by predisposing others to be resistant to offer assistance, assuming that they possess the skills necessary to solve their own problems and are simply unwilling to use them.

These "apparently competent" behaviors may be the result of a number of factors. First, as Millon (1981) suggested, the defining characteristic of this disorder may be that individuals are "stably unstable." Competencies that are displayed in one context simply do not generalize for individuals with BPD to other situations. This may be due to learning that occurs in one mood state or situation that simply does not generalize to other mood states or situational settings (see Mischel, 1968, 1984). Given the extreme fluctuations and unpredictability of moods in individuals with BPD, it would be most difficult to predict when abilities performed in one setting would be available in another.

A second behavioral pattern that may contribute to the display of apparent competence is the learned pattern of masking negative emotions that was encouraged in the invalidating environment of childhood or family of origin (Linehan, 1993a). The individual may automatically inhibit the display of negative emotions, placing the observer in the position of assuming that nonverbal displays are congruent with inner experiences. Thus, an observer may not even be aware that the individual is in distress. In addition, individuals with BPD also may have adopted some of the expectations of their early environments, namely, that they will be consis-
tently competent across situations. Despite their experience of unpredictability and of discomfort or distress in a given situation, they may communicate assurances that are based on others’ expectations.

Finally, clinical observations suggest that individuals with BPD are able to respond with competence in two specific interpersonal situations: Either the person is in the presence of a supportive, nurturing individual or he or she has the perception of being in a secure, supportive, and stable relationship. For example, in a therapy session discussion of distressing events may proceed smoothly, given that the client perceives the therapist as supportive. Hours later, however, the therapist may receive a call from the same client who is now experiencing great distress in response to the session. It would appear as though the supportive influence of the therapist is reduced when she or he is no longer present with the client. It may be difficult for significant others in the client’s life to understand how the client, in the presence of the painful stimuli, can act competently and then fall apart later. Again, the client may be punished for reaching out at this time by those who infer motives of manipulation as a result of their own confusion as observers.

The dialectical dilemma for individuals with BPD is to resolve their experiences of moving between the extremes of either communicating effectively to others their need for assistance in coping and, conversely, dealing with the shame of asking for help and the fear of losing significant others who provide assistance (Linehan, 1993a). Learning to help oneself involves learning to communicate effectively when one needs assistance and to predict situations wherein one may find oneself in need. The pattern of short-term versus long-term gains must be examined. Secondary gains that reinforce passivity (i.e., reduced performance anxiety, relational benefits, etc.) are poor exchanges for the long-term costs, which may include lower self-efficacy, a restricted range of skills, and, ultimately, reduced freedom to alter one’s own circumstances. The behavioral view of self-control, which stresses the individual coming more under the control of long-term contingencies than short-term contingencies, is the dialectical tension that must be uncovered and addressed. Clients who refuse to acknowledge or consider long-term effects of their behavior are at the mercy of short-term payoffs. Thus, communication to others must be improved to combat the judgments resulting from apparent competencies (change in strategy), and a realistic assessment of which behaviors the client is actually able to perform (acceptance) is necessary so that the client does not fuel the problem by asking for help when he or she does not need it.

The dilemma for the therapist is to become more responsive to cues and patterns that predict difficulty for the client and to recognize the client’s true capabilities so as not to unnecessarily leap in and offer assistance. Emphasizing the difficulty of change (acceptance) and requiring that clients actively participate in solving their problems (change) is the bal-
Unrelenting Crises Versus Inhibited Grieving

Many of the BPD individual’s characteristic dysfunctional behaviors are in response to a sense of being in a state of chronic, overwhelming crisis (Linehan, 1993a). High reactivity combined with a slow return to baseline create a situation in which successive events continue to drive the emotional response system, never allowing the individual to “catch his or her breath,” so to speak. Using Selye’s (1956) model of stress response, the client is constantly approaching the “exhaustion” stage of the stress adaptation cycle. Poor episodic memory, a characteristic of parasuicidal individuals (Williams, 1991), may decrease the ability to remember more positive emotional states or to notice the cyclicity of despair and hope. The therapist’s understanding of the overwhelming sense of helplessness in the face of the onslaught of minor crises may help in working with the repetitive parasuicidal and self-abusive behaviors exhibited by the individual with BPD. When combined with resistance to helping on the part of others in the environment (often a result of the client’s apparent competence), the sense of isolation for the client facing a loss may increase dramatically, leading to a more severe sense of hopelessness and possibly even completed suicide. The postulation of BPD as an emotional disorder leads to interventions to treat emotional hyperreactivity, establishing a dialectical tension within treatment (see next section) that the client must resolve, thereby modifying his or her emotional responding.

The term inhibited grieving refers to the repeated occurrence of trauma and loss combined with the inability of individuals with BPD to fully experience and resolve the events. Individuals with BPD have a phobic response to emotions, particularly those associated with trauma and loss. The accumulation of loss without subsequent emotional experiencing and processing may lead to two consequences. First, significant early or unexpected loss may result in sensitization to later loss (Bristed & Callahan, 1984; Callahan, Bristed, & Granados, 1983; Parkes, 1964). Second, a pattern of many losses may ultimately serve to inhibit the process of grieving itself (see “bereavement overload”, Kastenbaum, 1969). These patterns also overlap with symptoms displayed in posttraumatic stress disorder. Individuals with BPD have been shown to experience more childhood loss (see Gunderson & Zanarini, 1989) than other psychiatric populations. Moreover, individuals with BPD treated by Linehan and her colleagues often exhibit a pattern that includes brief exposure to the loss through obsessive rumination, followed by an immediate attempt to distract or otherwise.
avoid the painful emotions associated with the exposure. Such behavioral
patterns have been shown elsewhere to contribute to the incubation of
distress responses (Gauthier & Marshall, 1977; Napalkov, 1963), in effect
heightening the response to the distressing event rather than alleviating
it.

The dialectical dilemmas for the client in synthesizing both ends of
the spectrum—inhibited grieving and unrelenting crisis—are two-fold.
First, it is difficult to do anything that may increase vulnerability, such as
allowing oneself to experience grief and mourning, when faced with un-
relenting crisis. Second, the behaviors involved in avoiding grieving (drug
or alcohol abuse, denial, high-risk behaviors) often lead to further crises.
In addition, avoidance behaviors do nothing to elicit social support for the
client's loss, nor does it lead to resolution of the trauma. Thus, the client
is caught in a pattern of jumping from the trauma of crisis to the complete
inhibition of experiences associated with it. Although emotional respond-
ing is addressed therapeutically through specific interventions designed to
modulate its degree of expression, the grieving process itself must be al-
lowed to be expressed more fully. If natural grieving is resolved through a
process of moving from intense loss to appreciation of the lost object,
resulting in some sense of satisfaction gained by having come into contact
with that which is now lost, then the dialectical need for the client is to
move toward appreciation. In other instances, grieving may be associated
with anger (as in the case of sexual or physical abuse). In this case both
emotional experiences are typically avoided or experienced as overweigh-
ting by an individual with BPD, and either anger or pain may elicit sec-
ondary responses such as guilt or shame that have been conditioned
through the responses to such emotions in childhood. As with crisis states,
dialectical treatment will involve exposing the client to the core emotional
responses while encouraging more skillful and adaptive responses to them.

The therapist, on the other hand, must attempt to remain focused on
the larger pattern of movement within the client and not be drawn into
attempting to resolve the unending carousel of crises. The therapist must
offer hope that there is resolution to the crises and that grieving is both
necessary and will not completely overcome the client. Simultaneously,
treatment must involve validation on the part of the therapist of the pain
and distress being suffered by the client (acceptance) and a demand that
the client alter his or her emotional responding in ways that facilitate the
experience of the emotion and modulate its intensity and duration
(change).

DBT AND AFFECT DYSREGULATION

DBT is a treatment that developed in response to a specific theory
concerning BPD, namely, that individuals with BPD are suffering primarily
from a difficulty in affect regulation. Affect, as defined in DBT (see Linehan, 1993a, for a more extended discussion of this), involves not only brain and physiological changes but cognitions (interpretation of events), attention to environmental events, and action urges. As such, DBT has developed strategies to alter affect in any number of ways through an intervention aimed at any of the events contained within the affective response system. This particular formulation of emotion and its role in behavioral dysfunction is congruent with the emerging view (see Greenberg & Safran, 1987, for a review) that places emotion as the core element in the organization of personality (i.e., Malatesta, 1990) and as an evolutionarily important response and motivator in the interaction between organism and environment (see Smith & Lazarus, 1990). Thus, Linehan’s drawing of the “boundaries” of emotion to include attending to environmental stimuli, cognitive interpretations, facial expressiveness, and action urges falls directly in line with current thinking on the subject.

DBT works with clients to sharpen their skills in attending to environmental stimuli (specifically, to widen their attentional focus and develop abilities to discriminate between relevant and irrelevant stimuli), alter cognitive patterns (i.e., take the perspective of the other actor and be more cautious in ascribing motives), change facial and body language, and improve on the quality and variety of actions available to the client when experiencing an emotion. Attention to any one of these will improve the client’s ability to modulate and regulate emotional experiencing; DBT attempts to move forward in a pincerlike maneuver to work on all aspects of the client’s affective experience and response by creating an environment in which the client is forced to develop new affective responses and thereby new emotional experiences. Behavior is not viewed as separable from emotion, and so to change behavior is to change emotion.

One of the more intriguing findings of emotion research involves the connection between facial expression and emotion (i.e., Ekman, Friesen, & Ellsworth, 1972). Emotions have not only motivational properties for the individual, but also may have become adaptive as signaling stimuli for others; the “hardwiring” between facial expressiveness and emotional responding is proposed to be an adaptive advantage by behavioral–expressive theorists (Ekman et al., 1972; Izard, 1977). Likewise, there is an impressive array of literature being gathered that indicates that changes in facial expression may not only be reflective of emotional changes, but may in and of themselves be instrumental in modulating the duration, intensity, or even activation of emotional experience (Duncan & Laird, 1977; Laird, 1974; Rhodewalt & Comer, 1979; Zuckerman, Klorman, Larrance, & Spiegel, 1981). Similarly, Barlow (1988) suggested that exposure-based procedures typically used to target fear-related problems are effective precisely because they block the typical action impulses of the person experiencing the emotion, which is flight, in the case of fear.
DBT uses this information to work with clients with BPD, most of whom demonstrate clearly maladaptive responses to emotion, and negative emotion in particular. The dialectic in treatment that must be maintained is to have the client experience an emotion and to block the client’s typical response patterns to that emotion. Both of these are change strategies for clients, and they may be balanced with an acceptance of emotional experience that is modeled by the therapist (emotions are, in fact, inevitable and may be viewed as important guides to people in interaction with their environment; the emotional experiences of clients are entirely acceptable) and with acceptance of the clients’ previous strategies to regulate their emotions as the best that they could do at the time. Becoming angry, self-abusive, or self-medicating may all be effective short-term strategies in dealing with an emotional system that is otherwise beyond control; they are simply not effective strategies in the long term or as a fixed set of choices.

Therefore, DBT uses contingencies set by the therapist (or contained within the treatment, such as mandatory vacation from treatment for missing four sessions in a row) to restrict the client’s ability to respond in typical ways. A commitment to end suicidal and parasuicidal behavior is a prerequisite for entering treatment, and, when combined with requests that the client phone the therapist before committing such acts and restricted access to the therapist following parasuicide, such commitments force the client to dig deeper into his or her response repertoire when faced with highly charged affective responses. DBT does not leave clients to their own devices in this respect, however. While blocking the typical action patterns through contingencies, the therapist is also providing a warm, accepting environment to keep the client in treatment and is directing behavior through skill training homework and phone strategizing. Thus, DBT dialectically moves the client from a (highly maladaptive) homeostasis of dramatic response to severe emotional dysregulation into a new tension between the opposites of blocked responding and emotional experience. The resolution of the new dialectic for the client is the new behaviors coached by the therapist, including physiological change (i.e., changes in facial expressiveness and body language to move the client toward the opposite emotion and shorten the duration of the present emotion), cognitive change (i.e., expanding of interpretive possibilities of environmental events), and modified action repertoires to improve adaptivity of response. Clients are slowly moved from attempts to rigidly control phenomena into a more dialectical manner of interacting with the environment, developing patterns of emotional responding that (a) are flexible, (b) more situation–person specific, and (c) maintain the clients’ contact with environmental (including physiological) stimuli while they regulate and modulate their own emotional experience. As such, clients are better able to use important information within their environment that may have been previously lost through poor attending prior to the emotional experience and loss of con-
tact during the experience as clients withdrew or exploded while attempting to eliminate the unwanted emotion. Such flexibility and environmental contact are necessary for the enhancement of a more dialectical lifestyle and are fundamental for the development of long-term adaptive interaction strategies.

THE DIALECTICAL THERAPIST

DBT is based on a biosocial model that holds in dialectical tension two different models of behavioral dysfunction: motivation versus capability. In the motivational model, it is assumed that clients are experiencing difficulties because they lack the motivation to change. This is not to say that they do not have the will, desire, or strength to change. Motivation may include diverse elements such as having adaptive behaviors inhibited by fear, guilt, or shame; being hampered by a reinforcement history that has reinforced maladaptive responses; or operating out of a set of dysfunctional beliefs. The capability model asserts that clients do not have the skills to be effective in their environments or to change their behavior and is a model often held within the drug treatment community as the basis for relapse prevention or harm reduction programs of change. DBT moves forward with both programs simultaneously, working with clients to change their motivation to change and to provide them skills and new behavioral alternatives to use.

In effect, the two poles of motivation versus capability mirror the fundamental dialectic within DBT, that of change versus acceptance. Clinicians must attempt to change the client’s motivation while accepting the client as he or she is, regardless of where the client falls on the spectrum of “skillfulness.” The tightwire that therapists must walk is placed between the client’s history and fear of being invalidated again (by therapist demands to change, which are statements that the client is not “right” as he or she is) and the client’s own knowledge that change is necessary to end the misery. The therapist, in essence, is in danger of invalidating clients by either demands to change or acceptance of them as they are. The synthesis of the dialectic is to do both simultaneously, or, failing that, to quickly move from one to another.

This is not to say that therapists should pretend to accept the clients while they wait for their work on change to produce results. Both ends of the dialectic must be played from conviction and communicated in ways that are credible to the client. DBT has no difficulty with this; the dialectical worldview maintains that within every truth is its opposite. It is almost always possible to validate some part of the client’s experience, and this is held to be an important aspect of treatment not just because it balances out the change strategies. In fact, clients with BPD are notoriously difficult.
to keep in treatment (cf. Koenigsberg, Clarkin, Kernberg, Yeomans, & Gutfreund, in press). One possible explanation for the success of DBT in keeping clients in treatment is that the treatment not only demands change, but also provides a therapeutic environment that validates their experience. Clients with BPD are so sensitive to any communication that even smacks of criticism that they must be validated throughout or the therapist stands a good chance of losing them. In addition, a focus on change re-creates the environment of the family of origin, which demanded that the clients as children mask their negative emotions and not express or react to negative emotional responses. In a similar vein, a treatment strategy that focused exclusively on the acceptance end of the dialectic would drive clients from therapy because it fails to validate the pain in which clients live and invalidates their own desperation to alter their situation.

A second level of therapeutic attention must be devoted to recognizing the dialectical tensions being displayed by a particular client. Dialectics is not merely the putting together of opposites; any given thing may contain many different aspects to which it is “opposite.” For example, a white circle may be considered to be opposite to a black circle, a white square, or a white sphere, depending on the relevant dimension being considered. The definition of dialectical tension is that “any difference that makes a difference for some purpose is a dialectical contradiction; if a difference makes no difference, it is not a difference” (Reese, 1993, p. 84). Thus, for different clients there will be different struggles, and resolution may come quickly to some situations and more slowly to others. Attention needs to be paid to the process and to the content of dialectical tensions in each client and to the dialectics involved in the relationship between client and therapist.

Skills Training

DBT attempts, therefore, to move forward on multiple fronts simultaneously. In standard outpatient DBT, there are four primary modes of treatment: individual therapy (addressing motivational problems); group skills training (addressing skills acquisition); telephone consultation (addressing skills generalization); and the supervision or consultation meetings for therapists (aimed at keeping therapists within the therapeutic frame and balancing clients’ behaviors that might pull them out of that frame; see Linehan, 1993a, 1993b). DBT also incorporates therapeutic modes that run the breadth of health care, and Linehan has consulted extensively with inpatient units implementing the program. Typically, inpatient units will contain many more modes of treatment (i.e., milieu, vocational rehabilitation, dance or art therapy, unit meetings, etc.) than are available or used in outpatient work. Group skills training is incorporated as a fundamental aspect of DBT, designed to focus exclusively on working with clients to
develop new (or more fully develop existing) approaches to dealing with stressful events or toward increasing interpersonal effectiveness. Participation in skills groups is a prerequisite of individual treatment, and there are strict guidelines surrounding attendance. Skills covered in the training balance skills in accepting life and events as they are in the moment (mindfulness and distress tolerance skills) with skills for changing oneself and the environment (emotion regulation and interpersonal effectiveness skills).

Mindfulness and Tolerance

“Mindfulness” is a set of techniques that Linehan adapted from her study and practice of Zen meditation techniques. They are also found within the Western contemplative tradition. It is considered a core skills set within DBT (Linehan, 1993a, 1993b) and thus is one of the first taught during skills training. Mindfulness training forms the backbone of the set of techniques that teach clients how to observe, describe accurately, and participate while taking a nonjudgmental stance, focusing on one thing in the moment, and being effective. These skills, together with the distress tolerance skills (strategies for tolerating crises and for cultivating a stance of radical or complete acceptance of reality as it is in the moment) directly address the side of the dialectic that deals with observing and participating in one's environment so that one may collect accurate feedback and make predictions about what the consequences of future actions may be; it is the segment of the dialectic that deals with planning actions and observing effects. Reese (1993) noted that, within the contextualist position, action precedes knowledge by providing information about the environment in which the action is performed. Thinking about what a peach might taste like does not provide information; biting into it does. Truth is arrived at, and hence the dialectic is resolved, when actions are successful in the world medium. Viewed from this paradigm, DBT is actually training clients both to engage more fully and to observe more clearly (i.e., improving the ability to do both by removing judgments) in order to act more harmoniously within their environment. As Wilber (1977) noted, “these Eastern disciplines . . . are not theories, philosophies, psychologies, or religions—rather, they are primarily a set of experiments in the strictly scientific sense of that term. They comprise a series of rules or injunctions which, if carried out properly, will result in the discovery of [awareness]” (p. 23). He pointed to traditions that have endured for thousands of years and continue to train young initiates in time-tested and proved techniques of increasing awareness and continues by observing that “to refuse to examine the results of such scientific experiments because one dislikes the data so obtained is in itself a most unscientific gesture” (Wilber, 1977, p. 23).
It is notable that many of the techniques (i.e., breathing) used in meditative practice are common across disciplines. Although DBT does not, during treatment, initiate discussions of the religious or spiritual contexts in which the practices originated, their presence within many spiritual disciplines enables a therapist to allay clients’ fears that they may be practicing something beyond the bounds of their own religious doctrines. Conversely, the practices may be couched in strictly behavioral terms to remove any spiritual or religious overtones and to foster compliance among clients who are avowedly antireligion.

The dialectic that is discussed in group skills training when introducing mindfulness is the interplay between “emotion mind” and “reasonable mind” (Linehan, 1993a, 1993b). Resolution of the dialectic involves entering the state of “wise mind,” which synthesizes and includes aspects of both arguments. As with all synthesizes, wise mind is more than simply the sum of its parts. Along with logic and emotion, wise mind incorporates the sense of knowledge often referred to as intuition; it relies on the deep interaction of all ways of knowing and is evidenced through wisdom. Most clients with BPD must be taught how to access wise mind, and some will need to be convinced that they even have access to such a state. Some clients are able to recall experiences of being centered and operating from “wise mind” including instances following a crisis or perhaps after a very settling conversation with someone with whom they have “connected.” Clients who cannot recall such experiences are asked simply to look for such states and are given a series of exercises (“experiments” in the language of Wilber, 1977) to enable them to reach that level of awareness. A more extensive discussion of the presentation of the skill is available in the skills training manual (Linehan, 1993b).

Regulating Emotions and the Interpersonal Environment

Other skills taught within the group training are designed specifically to target what Linehan theorized to be deficiencies in the BPD individual’s ability to regulate himself or herself and his or her interpersonal environments (Linehan, 1993a, 1993b). Emotion regulation is taught, including instruction on how to identify and label current emotions, obstacles to changing emotions, reducing vulnerability to “emotion mind,” ways to increase the occurrence of positive emotional events, and the use of “opposite action” as a means of regulating emotional response. Interpersonal effectiveness skills are also taught. Although clinical observation has indicated that individuals with BPD frequently possess good interpersonal skills, they often are unable to apply the skills in the appropriate situation. Their belief patterns or intense emotional responding often get in the way of appropriate use of the skills that they have. Distress tolerance and emotion regulation skills are often necessary to ensure successful application of inter-
personal skills, and so DBT recognizes the need for interpersonal skills to be advanced only as quickly as other skills improve. The groups skills training modules have been put into manuals (Linehan, 1993b), complete with worksheets for therapists interested in studying the training, and the workbooks are required as a textbook for clients attending the training.

One other point that can be made concerning the development and implementation of groups within DBT demonstrates an example of dialectical theory influencing a therapy decision. The need for group skills training evolved because, despite the best of intentions to train clients in skills that they needed desperately, individual therapy simply could not seem to get beyond dealing with the weekly need to manage crises with clients; there was never the lull in the process into which skills training could be introduced. Linehan’s initial inclination was to have groups be closed forums with fixed membership for the duration of the commitment (one year). She and her colleagues, in fact, led several groups under these conditions. However, it became increasingly clear that to teach dialectical principles of change and synthesis within a closed system was contradictory and in some ways worked against the acceptance and accommodation of change that she intended clients to be learning. Thus, the decision was made to allow clients to join at 8-week intervals (between modules) while those who had completed their year dropped out. The “acceptance of change” has also been introduced into individual therapy, and therapy now is more pointedly focused on clients learning to deal with the natural and ongoing fluctuations of events both within therapy and in their home environment.

Dialectics in Treating the Therapist

At the same time that the therapist is treating the client, the therapist is also being treated through consultation with the treatment team (Linehan, 1987, 1993a). The team is composed of other mental health professionals who have committed to working within the DBT framework, some of whom may be working with the client being seen in individual therapy. Many different modes of treatment may be represented on the DBT supervision team. Included may be the psychiatrist or nurse who prescribes medication, social workers, psychiatric nurses and aides providing milieu therapy, individual therapists, skills group trainers, back-up therapists, and so on. Anybody involved in treating the client may be present on the team, and there are often professionals present who are working with different clients. It is not necessary for every mental health worker who deals with a client undergoing DBT treatment to be working from the same orientation. Professionals not working from the DBT framework, however, do not attend the consultation sessions. DBT includes provisions

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for working with a health care community that may not even be familiar with its principles or strategies.

Consultation to the therapist is a necessary part of doing DBT (Linehan, 1993a). As a regularly scheduled activity it fulfills many functions. Primary is its function as dialectical counterweight to treatment of the client. The team or supervisor applies DBT to the therapist, allowing the therapist to be the recipient of acceptance and change strategies even as he or she is applying these same strategies with the client. A system of treatment is established wherein the transactions between client and therapist are brought into a dialogue among the therapist and individuals on the DBT consultation team. Therapy is thus modified from the client up and from the consultation team down, with both subsystems being affected by the presence of the other. The team works to keep the therapist in therapy with the client and the therapist works to keep the client in therapy. Thus, team members may need to cheerlead and support the therapist in addition to providing a dialectical framework for the therapist to refresh his or her perspective on treatment.

The team is also required to help the therapist maintain balance in the therapeutic relationship. Assuming some dynamic tension among therapist, client, and team, balance may be regained by the consultation team moving closer to the individual therapist and allowing him or her to gain distance from the client, or by backing off and thereby forcing the therapist to move closer to the client. Primarily, however, the consultation team provides a context for DBT, reminding the therapist of important principles that may be overlooked or providing a dialectical balance to the individual, subjective viewpoint. Prerequisites for supervision are regular attendance on the part of all participants and a willingness to engage in open exploration of difficult situations through a nondefensive application of DBT principles. As with individual therapy itself, the group consultation meetings are part education, part support, and part challenge to individuals to widen their perspective or balance their view. Humility is a necessary ingredient for all who participate, for those who instruct today will be taught tomorrow, and those whose sight is clear now will discover their own blindness at some point. The meetings are weekly reminders to remain grounded and supportive.

SUMMARY

This has been a necessarily brief introduction and overview to some of the ways in which dialectics has been incorporated into the therapeutic process in DBT. Note that the understanding and application of the principles of dialectics to treatment processes continues to evolve within DBT. Mahoney (1993) discussed this same process in work currently being done.
in psychotherapy theoretical integration in which there is an “emphasis on open-ended dialogical process” (p. 7) that has no endpoint, only an ongoing open forum for new views. One key to maintaining the development of DBT has been, and will continue to be, the use of dialectics as a tool to guide the therapist’s actions and inquiry. Dialectics also is the process that furthers the theory of behavior change underlying DBT; experiments in the real work of therapy help to further modify the theory, which in turn modifies the strategy used. Interestingly, what began as an attempt to label and identify a treatment has become the process directing and forwarding new innovations within the therapy.

As mentioned earlier, there is no therapist without a client, no beginning of treatment without end goals, and no theory devoid of practice. It remains an empirical question whether therapists need to understand and model dialectics in order to effectively practice DBT. If, as seems possible, clients with BPD are truly deficient in their own ability to think and act dialectically, then explanation and modeling would seem to be important aspects of the treatment; it is not enough to simply “do dialectics” to them. Indeed, within the system we have described, it is not possible. Therapists are consistently engaged in some dialectical process when doing therapy, operating out of theories of behavior change and (hopefully) responding to client responses generated by the past intervention in determining the next move. A focus on dialectics primarily shifts one’s attention to the process occurring rather than to the endpoint toward which one is moving.

In this chapter we have discussed the rudiments of philosophical dialectics and touched on the application of this philosophy to therapeutic theory and, more specifically, the dialectical processes for clients and therapists that are the focus of DBT. Of course, there may be similar or vastly different dialectical tensions among clients or among clinical populations. Similarly, the dialectical tensions between client and therapist may vary among pairings or across sessions. What we have intended to demonstrate is the process of using dialectics as a theory to guide therapeutic practice, noting other phenomena within psychology that are currently being viewed dialectically, and touching on the growth of dialectics as a paradigm in other scientific disciplines. The impact of such a shift, we believe, has yet to be realized.

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