REVIEW ARTICLE

Dialectical Behaviour Therapy : Overview, Origin, Philosophy and Mediators of Therapeutic Change : Dialectical and Core Strategies

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ABSTRACT

Dialectical Behaviour Therapy (DBT) has been considered effective evidence based psychotherapy for Borderline Personality Disorder in eight randomized clinical trials. This narrative review provides a brief overview of the treatment and purports to inquire into the dialectical philosophy of DBT and examine the dialectical and core strategies for potential mediators of change: few of those aspects that are unique to this treatment.

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INRODUCTION

For a condition as severe and debilitating as Borderline Personality Disorder (BPD) with high prevalence, high hospitalization rate, grave risks for deliberate self harm and self injurious behaviour, hostility proneness, poor compliance to traditional treatments and poor outcome, it is not unsurprising for the clinical community towards becoming enthusiastic on encounter with any form of psychotherapy which would yield even marginal efficacy in outcome studies.[1] Psychotherapies' repertoire boasts of 'modern evidence based therapies' in the likes of Transference Focused Therapy, Mentalization based Therapy, Schema Focused Therapy, Cognitive Analytic Therapy and yet Dialectical Behaviour Therapy (DBT) appears to have touched a chord with researchers and clinicians alike like no other.[2] DBT as an evidence-based treatment for BPD have been demonstrably effective in eight randomized clinical trials.[3] American Psychological Association (APA) opines well established treatments are those that: "(a) have been subjected to a minimum of two group designs or a large series of single-case design outcome studies conducted by different investigators, (b) are demonstrably superior to placebo or more efficacious or equivalent to an already established treatment, (c) follow treatment manuals, and (d) clearly specify characteristics of patient samples",[4] criteria fulfilled by DBT. The basic assumption of this treatment is that skills deficit and insufficient motivation contribute to the failure of BPD individuals to function effectively in everyday life situations,

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especially on encountering stressful events while the treatment goal,[5] apart from targeting the obvious behavioural skills, is best described as multi-staged whose ultimate aim is to "build a life worth living".[6] This article purports to discuss, albeit theoretically, DBT's origin, conceptualization of therapeutic change and how the core catalytic strategies bring about change.

OVERVIEW

Developed by Dr Marsha M. Linehan, a psychology researcher at the University of Washington, DBT, a form of Cognitive Behaviour Therapy, is a comprehensive treatment program which seeks to balance its proximal aim of reducing problem behaviours with its goal in perspective of efforts to build a life worth living. Based on the biosocial theory It emerged as a treatment for 'chronically parasuicidal women with borderline personality disorder' and has been adapted for several other apparently intractable behavior disorders with emotion dysregulation at the core like borderline patients in outpatient, inpatient, and crisis intervention and forensic settings,[7-12], borderline patients with substance use disorders,[13,14] suicidal adolescents with depression,[15,16] patients with eating disorders,17 depressed elders,[17-20] and adults with attention-deficit/hyperactivity disorder.[21] An important issue for further research is whether this therapy is effective for the entire range of clients with borderline personality disorder or whether it is primarily a treatment for deliberate self-harm. The lack of evidence that it is efficacious for other core features of borderline personality disorder, such as interpersonal instability, chronic feelings of emptiness and boredom and identity disturbance, has led to the suggestion that dialectical behaviour therapy might be the treatment of choice for people with severe, life-threatening impulse control disorders rather than for borderline personality disorder per se.[22]

The treatment comprises of several stages (Table 1) whereby it is oriented to first get action under control through improving behavioural skills to deal with damaging self harm behaviour or inattentiveness or dissociating during sessions for instance, then to help the client to feel better through handling 'quiet desperation' they are likely to be left with after Stage 1 DBT, to resolve problems in living and residual disorders, and finally to discover joy and, for some, a sense of transcendence. However, the research on DBT, with respect to clients' with severe and multiple problems which has found favour with efficacy studies in stabilizing and controlling self-destructive behavior and improving patient compliance, is mostly about Stage 1.

Stage	Target
1	Increase behavioural skills
	a. reduce life-threatening behaviour
	b. reduce therapy interfering behaviour
	c. reduce quality-of-life-interfering behaviours
2	Improving the experience of the patient
3	a. Deal with problems in living;
	b. Moving to "ordinary happiness and unhappiness"
4	a. Overcoming sense of incompleteness
	b. Development of a sense of sustained joy

Table 1 : Stages of DBT[6]

The treatment is committed not only to enhance client capacities but also to boost therapist capabilities and motivation during the process. In standard DBT, these functions are divided among modes of service delivery; including *individual psychotherapy, group skills training, phone consultation, and therapist*

consultation team.[23] While group or individual skills training enhance capability of the client, individual psychotherapy targets client motivation apart from skills strengthening. Telephone contact with client ensures effective application of coping skills and the therapist consultation team keeps the spirit of therapy alight in therapists.

There are more than 50 skills grouped into four modules, each designed to target a different area of skills deficit in BPD :

a. **mindfulness skills :** emphasizing observing, describing, and participating in the present moment effectively and without judgment;

b. **emotion regulation skills :** including an array of strategies for changing emotions quickly, as well as strategies for changing the tendency to respond emotionally in everyday life situations;

c. **interpersonal effectiveness skills :** ranging from basic social skills training, to assertiveness and goal-oriented interpersonal problem solving; and

d. **distress tolerance skills :** including short-term strategies to control impulsive actions and long-term strategies to radically accept difficult life events.[6]

Skills training being a crucial measure of change in DBT, DBT-Ways of Coping Checklist (DBT-WCCL) was designed to assess use of skills taught in DBT using the Revised Ways of Coping Checklist.24 It was found to successfully capture DBT skills use as well as use of dysfunctional coping in difficult situations.[25]

ORIGIN

In her tryst with chronically suicidal patients who have BPD, Dr Linehan found standard cognitive and behavioral treatments devoted on helping patients 'change' their thoughts, feelings, and behaviors leaving them feeling invalidated, criticized, emotionally overwhelmed and prompting outbursts and/or attrition. However, if a treatment were given to 'acceptance', it would invalidate the seriousness of the patients' suffering and the urgent need to produce change. Patients then viewed their therapist as ignoring or minimizing their suffering and responded with extreme rage and hopelessness. In short, patients experienced both promptings for acceptance and promptings for change as invalidating their needs and their experiences as a whole, with predictable consequences of emotional and cognitive dysregulation and failure to process new information, which could be conceptualized as "dialectical failures".[5] Moreover, individuals with BPD often unwittingly reinforce the therapist for iatrogenic treatment (e.g., a client stops attacking the therapist when the therapist changes the topic from the one client is afraid to discuss to a pleasant or neutral topic) and punished them for effective treatment strategies (e.g., a client attempts suicide when the therapist refuses to recommend hospitalization stays that reinforce suicide threats).

Dr Linehan's series of therapy observations and discussions with her research team beginning in the early 1980's found her applying procedures not traditionally associated with cognitive or behavior therapy, which somewhat rapidly switched between warm accepting and blunt confrontational stance and announced the serendipitous arrival of DBT, which whisks both the recalcitrant client and his/her exhausted therapist into a dance, harmonically weaving acceptance and change in a therapeutic whole, lyrically drawing from dialectical philosophy.

DBT : DIALECTICAL PHILOSOPHY : PHILOSOPHY OF CHANGE

To DBT, **dialectical philosophy** is a worldview. This emphasis on dialectics brings together principles of eastern Zen and western contemplative practices. The best illustrative of Buddhist dialectical methodology may be found in an example from the *Prajñāpāramitā H□daya* (1st century BC) - "Form is emptiness/ emptiness also is form/Emptiness is no other than

form/form is no other than emptiness" - the concept of *sunyata* is central to the Buddhist understanding of material life - and exposition of truth through dialectics is the method of transcending opulent life.[26] The concepts of this doctrine elaborated manifold over time by thinkers like Acharya Nagarjuna (150 - 250 BC). Nagarjuna's central work, *Madhyamika-karika*, sets the fundamentals of Buddhist dialectics - "...there is neither origination nor cessation, neither permanence nor impermanence, neither unity nor diversity, neither entrance nor exit in the law of *Pratitya-samutpada* (dependant - arising)". The Buddha demonstrated dependent arising with the "wheel of life" (Pāli : *bhavacakka*; Sanskrit : *bhavacakra*), which depicts the cycle of rebirth. The wheel of life is supposed to illustrate the fact that nothing in our conventional reality "is brought about by any single cause alone, but by concomitance of a number of conditioning factors arising in discernibly repeated patterns." Thus, everything is dependent on and relational to something else like in a spider's web, where each entangled string is an important part of the complex and "as far as one analyses, one finds only dependence, relativity, and emptiness, and their dependence, relativity, and emptiness" and so ad infinitum. This may broadly be said to represent Buddha's "principle of relativity" or *sabhava-sunyata* (the emptiness of self-being). And henceforth Nagarjuna sets out to prove that no conceptual system can hold absolutely true and that contradiction is inherent in all systems of description and thought.[27]

Modern day dialectics was composed to maturity by German idealist George Wilhelm Friedrich Hegel (1770 - 1831). His method is often quoted as to consist of the triad of "thesis - antithesis – synthesis".[28] According to Hegel, the process by which a phenomenon, behavior, or argument is transformed is the dialectic, which involves three essential stages: (1) the beginning, in which an initial proposition or statement (thesis) occurs; (2) the negation of the beginning phenomenon, which involves a contradiction or "antithesis"; and (3) the negation of the negation, or the synthesis of thesis and antithesis. Essentially, tension develops between thesis and antithesis, the synthesis between the two constitutes the next thesis, and the process is repeated ad infinitum. Karl Marx (1818 - 83), a student of Hegel, appreciated the concept of dialectics and banishing idealism as fantastical ruminations, set an example of application of philosophy in social sciences differing from the rigid a - priori formulation of Hegel and it is to him that 'dialectics' is popularly traced back today.

When dialectical philosophy is applied to human behaviour it helps envision reality as interrelated, ever changing with operative oppositional forces and therefore, behaviour ensuing, contextual at best.

Principle of	Implication
I. Interrelatedness and Wholeness	• Systems perspective on reality; analysis of parts of a system of limited value till clearly related to whole • Identity is relational; Boundaries temporary • Challenging Western individuated self with relational or social self : e.g. interrelatedness of skill deficits like self-regulation skills as well as better skills for influencing the environment
II. Polarity	• Idea : Propositions contain within them their own oppositions

Principle of	Implication
	• **Polarity I** : Need for the client to accept self as in the moment and need for self to change • **Polarity II** : Getting what client needs and loosing what s/he needs if s/he becomes more competent • **Polarity III** : Maintaining personal integrity and validating one's own views of one's difficulties and learning new skills that will help one emerge from suffering
III. Continuous Change	• Tension between thesis antithesis forces within each system produce change • The new state 'synthesis' following the change also comprised of polar forces; • Change is continuous; the essential nature of life : Making client comfortable with change

Table 2 : Dialectical World View in DBT[5, 6]

The Biosocial Theory proposes that in individuals with BPD, there are reciprocal exchanges between a punitive invalidating environment, which discounts and distorts their attempts to communicate and begets physical, emotional or sexual abuse, and a predisposition for emotional vulnerability that leads to affective instability.[29] Thus there is proneness to disarray in thought action tendencies in the face of emotional arousal and use of maladaptive mechanisms to counter the powerful and distressing emotional experiences.

Treatment balances the patient's desire to eliminate all painful experiences (including life itself) with a corresponding effort to accept life's inevitable pain. In the tradition of Zen principles, DBT advocates **Radical Acceptance**. There are three parts to radical acceptance. The first part is accepting that reality is what it is. The second part is accepting that the event or situation causing pain has a cause. The third part is accepting life can be worth living even with painful events in it. It follows, suffering arises from both pain and non-acceptance of it. Without the synthesis between this desire to eliminate and effort to accept, the patient's problems tended to converge and overwhelm both patient and therapist; with it, the patient can work on changing one set of problems while tolerating at least temporarily the pain evoked by other problems.

DIALECTICAL AND CORE STRATEGIES : MECHANISM OF CHANGE

If skills training constitute the 'what' of treatment in DBT, strategies form the 'how' of it. Four broad categories of the strategies used in DBT are :

a. *Dialectical Strategies :* These characterise the treatment.

b. *Core Strategies :* These consist of Problem-solving and Validation strategies, which together with Dialectical Strategies define DBT.

c. *Stylistic Strategies :* These are about the style and form of therapists' communication and interpersonal relating.

d. *Case Management Strategies :* These provide guidelines for application of dialectical and core strategies to case management problems like dealing with significant others in the patient's environment.

CHANGE ASSOCIATED WITH DIALECTICAL STRATEGIES

Dialectical strategies harness the treatment to bring forth change in the context of acceptance of reality per se. They are meant to highlight the tensions engendered by contradictory emotions, thoughts, values, action tendencies within an individual and between the individual and his surroundings. The therapist often augments such tension through the devil's advocate strategy or ones such as entering the paradox (moving beyond logic or intellect to see that things can both be true and not true), extending (emotional equivalent of devil's advocate), providing a thesis (argument) reasonable enough to seem real but extreme enough to stimulate antithesis (counterarguments) from the patient thus working for a synthesis of opposite opinions, feelings, or thoughts (e.g. idea such as both or neither is right in an argument); using metaphor (e.g. refusing to wear winter gear in snow: therapy interfering behavior); oscillating speed and intensity in interacting with the patient; and using movement fluidly in session to keep the patient awake and slightly "off balance." Each dialectical strategy essentially involves balancing or synthesizing dialectics that occur in session.

The strategies in essence are not unique to DBT and have been a part of psychotherapy since long. Also, it is CBT to which DBT openly owes its allegiance. The idea is to begin with what the patient understands (e.g. analogy or metaphor) and impinge on that which s/he does not (therapy process) through the unconventional and eccentric to 'open' him or her to the environment. Effortful and elaborative processing takes place of information which individuals find hard to believe.[30]

By enhancing the client's 'orienting response', the client's involvement in the therapy process is ensured, which is an important mediator variable in process outcome research.[31] The therapist deftly vacillates between polar extremities opening up to the patient a hitherto unexplored worldview and flexibility with a panache which the patient would be tempted to model by virtue of its outlandish illogicality and a sense of liberation from the inflexibility and ineffectiveness of his/her thought-action-emotion tendencies. Moreover, dialectical strategies make in vivo learning possible which warrants behavior change. Counterarguments are generated from patients in the face of the implausible arguments presented by the therapist implying a shift in the patient's position of thinking and reasoning (e.g. devil's advocate strategy). Change is more likely when one (patient) argues for it than when another (therapist) attempts to enumerate its benefits.

Since DBT essentially evolved as a treatment for the emotionally unstable and chronically parasuicidal, DBT has given as much thought to its patient-therapist system as it has to the patient per se. Treatment here is not only about patient's acceptance and change about his/her condition but also about the therapist's wholehearted willingness to let go off attachment to any 'goal' or 'idea' and reiterate between positions. In fact, it is a dialectical perspective that allows the therapist to give up being 'right' for being 'effective' and to integrate validation and change when polarization occurs between patient and therapist. For instance, the therapist can see that the patient considers him non-compliant and cold to the patient's need to extend the therapy session (validation) however he cannot see how she would utilize her interpersonal and distress tolerance skills if he does comply (change). The therapist, as human as the patient, is influenced by behavioural principles of reinforcement and punishment and without the dialectical stance could fall prey to iatrogenic treatment. To maintain therapist efficacy,

the therapist consultation team, especially oriented to dialectical philosophy, creates a system to discuss the therapist behavior and monitor and modify the patient-therapist dyadic exchanges. The therapist's behavior (e.g. self invalidation, poor participation in therapist consultation team, tendency to be autocratic) is changed and shaped in the same spirit as the patient's. Therapist's motivation and skill is what translates into effective treatment in a dialectical framework.

CHANGE ASSOCIATED WITH CORE STRATEGIES

VALIDATION

DBT rests on the biosocial theory emphasizing invalidation as reciprocally related to emotional dysfunction in patients with BPD. Validation strategies are thus direct acceptance strategies in DBT whereby the patients are made to understand that their behavior is understandable in their current life context. These strategies demand of the therapist active observation to remain awake to the unstated need of the patient and accurate reflecting to help the borderline patient blinded by self mistrust identify her discounting of her own perceptions despite oft accurate observations. Also, apparently unique to DBT in its emphasis, the therapist scans the patient's responses for that grain of truth 'hid in…bushels of chaff' assuming, albeit dialectically, there is some validity ingrained in every response. That is to say, even if a fragment of the response is valid, it is unmasked and addressed. Discovering authenticity in the patient's words makes therapist genuinely help patient validate herself.

Interestingly, however self-evident validation strategies might appear to DBT, the amount in which it is required would require tempering with the change based strategies. The validation-to change ratio would be higher for the patient who retreats when felt confronted and fails to assert than one who would hold forte nevertheless. Validation strategies versus change strategies is likened to edge of the cliff behavior; while therapy pushes the patient to the fringes, validation pulls them back to secure territory.

Validation extends verification and coherence to BPD's unstable self-image, which, associated with excessive self-criticism, indicating identity disturbance, remains one of the characteristic features of BPD.[32] This instability is a major source of discomfort for BPD individuals as it robs them of the crucial sense of coherence in self views which appropriate self verifying feedback from significant others bring.[33] Validation, for instance by teaching emotion observation and labeling skills and reading emotions, helps initiate the process of organizing emotional experiences and effectively anticipate social interactions and future events by improving sense of self. Thus it strengthens self-direction. Also, pitted against overpowering obstacles by way of disconfirmed self-constructs, BPD individuals tend to experience negative affectivity which in turn leads to emotional upheaval and consequent disruption of cognitive functioning and task performance. Validating self-views for instance through focusing on the patient's capabilities or modulating external criticism tends to optimize the process and make in session learning of appropriate skills possible. Validation ensures a self- confirmatory environment that also serves to keep up the motivational level of the client in therapy.[34, 35] Through skillful use of behavioural processes of contingency management and modeling the therapist could reinforce and model skillful self-validating behavior in the sessions.[5] In fact, there are indications from research on therapeutic process that non-arbitrary, natural, socially mediated in session reinforcement is invaluable.[36]

PROBLEM SOLVING

These strategies are at the heart of the action and therapeutic change in DBT with individuals who oft impress as helpless and passive. While the entire DBT program, albeit any form of Cognitive Behavior Therapy, is an application of problem solving, these strategies are used to figure out effective case management strategies and specific daily life

problems of the client. Indeed, as a process it is two folded : understanding and 'accepting' the problem through behavior analysis, insight and didactic strategies and generating and considering relevant alternatives for 'change' through solution analysis, orienting and commitment strategies.[5]

Behavior analysis is intricately linked with Stage 1 DBT (mentioned in a previous section). Thus it bears the brunt of the emotional dysregulation which epitomize BPD, is difficult to implement and susceptible to confounding and assessment errors. Identification of the problem behavior is followed by choosing specific instance of the behavior to analyze and then attending and filling up links in the chain while maintaining patient cooperation. Since chain analysis brings to the fore specific dysfunctional aversive events (e.g., act of self mutilation), the process acts as a punisher for displaying target behavior. Moreover, disclosure and discussion of several facets of the maladaptive emotionally driven response, provides exposure to the emotions without ensuing reinforcement that the maladaptive behavior apparently brings.[37] It could also influence the patient's skill of interpreting the pattern of dysfunctional behavior and perhaps increase the likelihood of application of more effective behavior learnt in DBT by enhancing stimulus discrimination or episodic memory.[31] Learning of skillful behavior itself is enhanced in this acceptance-based problem solving strategy through in vivo exposure to both assessment and management of difficult emotions though reiterative revisiting of events and classically conditioning analysis and effective solution generation with them. It follows; stimuli that brought about maladaptive behavior (e.g., self mutilation) would become conditioned stimuli for adaptive behavior (e.g., self assertion).[31] Also, such maladaptive non normative behavior have been associated with disconcerting shame which in turn hinder effective problem solving and promote withdrawal and avoidance. Necessity of verbalization of shame in therapy works like mindfulness or opposite action,[38] and provides non reinforced exposure through which the association between maladaptive behavior and shame would expectedly weaken and give way to engagement in problem solving. Learnt skillful behavior is helped generalized in the naturalistic setting through the provision for telephone consultation with the therapist. It works through shaping the patient's coping behaviors in the moment and serve as cues to extinction training in the therapy sessions.[39, 40]

Solution analysis much like CBT is about troubleshooting and pushing brainstorming. Together with orienting and commitment strategies it is also about emphasizing on understanding the rationale behind what has to be learned and what is expected of the patient in therapy and in a particular task, step by step rehearsal of the actions to try, commiserating (e.g., using Soothing) all the while with the patient as to how difficult patient's tasks could be, yet pointing out the necessity of learning/change however liked or loathed by patient and/or therapist (Polarity III, Table 2, previous section). Commitment strategies work through building a sense of control in the patient and shaping and reinforcement of elicited target behavior. Compliance techniques like 'Foot in the Door,[41] and 'Door in the Face,[42] are called forth to strengthen patient's commitment to reach goals through principles of consistency and reciprocity respectively. 'Foot in the Door' technique also finds alternative in the explanation that the tactic alters people's interpretation of situations that activate attitudes enhancing compliance.[43]

Perhaps the only difference one would find here from CBT is in terms of the reiterations required of the strategies for the process to be effective; commitments are made again and again, insight is hard to sight and harder to 'keep', behavior analyses could be never ending and are likely punctuated by therapy interfering behaviors, alternative solutions are hard to find and harder to translate to behaviors. They often warrant additional skills training, cognitive modification, exposure-based interventions to counter interfering negative affectivity and putting to practice behaviors generated.[5]

THEREFORE

Widely accepted as evidence based treatment for BPD, DBT is based on dialectical philosophy, which brings together principles of eastern Zen and western contemplative practices. Buddhist dialectics illustrates the interrelatedness of reality and the inherent contradictions in all systems of thought and Hegelian dialectics posits that tension develops between thesis (initial proposition) and antithesis (contradiction; negation of thesis), the synthesis (negation of negation) between the two constitutes the next thesis, and the process is repeated ad infinitum. Dialectical strategies in DBT are meant to highlight and augment the tensions and arousal experienced by the emotionally vulnerable individuals with BPD to orient, 'open up' and involve the client in the therapy process to make elaborative processing of information and new learning possible. Counterarguments (antithesis) are generated from patients in the face of implausible arguments (thesis) presented by the therapist implying a shift in the patient's position of thinking and reasoning and precipitating a new understanding of reality (acceptance).

The basic premise for treatment lies with the Biosocial Theory for the ineffective action tendencies associated with emotional dysregulation, which the validation strategies target. They work through lending stability to BPD's crumbling self-image and a self-confirmatory environment that enhances insufficient motivation issues of BPD. Problem solving strategies, at the heart of action in DBT, work through initiating generalization of learnt skillful behavior and through non-reinforced exposure to the distressing emotions (shame, guilt) bring forth more adaptive behavior.

As process outcome research studies hold, effective psychotherapy can neither be delimited by its technical procedures nor solely by warm therapeutic relationship; it is more than what the therapist does intentionally or otherwise and more of what the patient experiences,44 DBT outcome measures vary and are mostly limited to measurable behavioural outcomes such as incidences of deliberate self-harm or suicidal thoughts. Two recent Cochrane reviews conclude that DBT does benefit those with BPD, but more robust evidence is needed.45 More research in the arena of mediator variables and mechanism of change are warranted to get insight into the hypothesized processes in which change occurs in DBT. This phase of an established treatment calls for component and process-analytic studies, dismantling studies, and studies designed to analyze response predictors in the long term,31 perhaps in the later stages of DBT. Such insights could perhaps take us back to the purpose of DBT's origin of building a life worth living for those hitherto on the edges.

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