

Dialectical Behaviour Therapy: A Critique and Evaluation

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The term "borderline" first appeared in psychoanalytic literature earlier this century. It tended to refer to patients who were neither completely neurotic or psychotic but were still very disturbed (Goldstein, 1995). This term has evolved and presently "borderline" generally refers to a severely disturbed personality (Ryle, 1997). The core features of the Borderline Personality Disorder are instability of mood, interpersonal relationships and identity (American Psychiatric Association, 1994). Suicide attempts are a common behavioural feature of this disorder.

Borderline Personality Disorder (BPD) patients with a history repeated suicide attempts are renown as a group of individuals who are difficult to treat (Miller, Eisner and Allport, 1994). Dialectical Behavior Therapy (DBT) is a treatment designed for individuals who meet criteria for Borderline Personality Disorder (BPD). It is specifically oriented to those borderline individuals, who as part of their disorder, also participate in para-suicidal behaviours. DBT is considered as one of the few therapeutic approaches that are considered as successful in treating these individuals (Roth & Fonagy, 1996). DBT may be the only cognitive and behavioural treatment procedures that is supported by controlled clinical evidence for reducing, long term, repeat suicidal behaviour in BPD clients (Roth & Fonagy, 1996; Van Der Sande, Van Rooijen, Buskens, Allart, Hawton, Van Der Graaf, & Van Engeland, 1997).

DBT was primarily developed by a clinician called Marsha Linehan in the late 1980' s and early 1990' s . Based only upon a review of the literature, the following critique will evaluate the use of DBT as a viable therapeutic intervention. It will begin by describing the historical context from which DBT developed. Then, a treatment overview will explain its goals, strategies and various treatment approaches such as individual and group. Derived from a bio-social theory of BPD and the integration of numerous treatment paradigms DBT has a broad theoretical foundation. The theoretical

perspective of DBT will be explored and discussed and supporting empirical evidence that is based upon controlled studies as well as anecdotal reports will be reviewed. Finally the limitations and assets of DBT both as a program package as well as model of treatment will be commented upon.

Historical Developments

Linehan (1993) ascribed the beginning developments of DBT to the early 1980s when she was working with para-suicidal clients and attempting to apply Cognitive Behavioural Therapy (CBT) to their behaviours. She stated that during weekly sessions her treatment sessions were observed by a team. It was verified that she was sometimes applying CBT with these clients but in addition to this she was also applying a number of other techniques and strategies that could be aligned to other therapeutic approaches or paradigms. These techniques included the use of validation, warm acceptance and empathetic reflection. However, these validating communication styles would often switch to blunt irreverent confronting comments. Her techniques also included paradoxical treatment strategies found in some systemic and paradoxical approaches. In addition, she found herself being influenced by Zen Buddhist meditation practices where there is an emphasis on acceptance of feelings rather than changing them.

The emphasis of CBT is on rational thoughts and changing cognitive distortions which are seen as the root of an individual's mental suffering (eg Beck, 1961). Linehan, on the other hand found herself drawing attention to intuitive non-rational thoughts as equally advantageous to rational thoughts and emphasising acceptance of painful emotional states and problematic environments rather than trying to change or modify them as with CBT.

Linehan's clinical experience formed the inspiration to develop an approach different from traditional CBT and she chose the term "dialectical" because its meaning seemed best to describe her approach. Published in 1993 Linehan wrote a text book

(1993) and skills manual (1993b) both of which give elaborate details about the theory and practice of DBT. Despite the misleading title of her text (" Cognitive Behavioral Treatment for Borderline Personality Disorders,") Linehan (1993) noted that DBT had a number of aspects that were different from traditional CBT. These were: 1/a focus on acceptance and validation of behaviour as noted above, 2/an emphasis on treatment-interfering behaviours, 3/an emphasis on the therapeutic relationship as a primary therapeutic factor and 4/the importance of dialectical processes as a focus for treatment.

Treatment overview

The main goals of DBT are:

1. to reduce life threatening and suicidal behaviours
2. reduce therapy interfering behaviours especially non-compliance and dropping out of treatment
3. increase quality of life and decrease behaviours that may have a severe effect on an individuals quality of life, and
4. increase general coping skills.

The DBT treatment package involves one to one individual psychotherapy, a group based skills training program, case consultations for therapists and phone contact with clients.

" In a nut shell DBT is very simple. The therapist creates a context of validation rather than blaming the patient, and within that context the therapist blocks or extinguishes bad behaviors, drags good behaviors out of the patient, and figures out a way to make the good behaviors so reinforcing that the patient continues the good ones and stops the bad ones" (Linehan, 1993, p.97)

At its most rudimentary level DBT endeavours to reduce the suffering experienced by the DBT client by altering maladaptive behaviours. From the clients view maladaptive behaviours (such as suicide attempts) are often seen as solutions for distress or

suffering that these clients may be experiencing. For the therapist view however, the maladaptive behaviours are often seen as the problems to be solved.

Strategies

" Strategies" have described as " Co-ordinated activities, tactics, and procedures that therapist employs to achieve treatment goals" (Linehan, 1993b, p27).

With DBT there are:

- core strategies,
- stylistic strategies,
- case management strategies,
- integrative strategies, and
- structural strategies.

The core strategies are the basic strategies used with treatment. The stylistic strategies are related to interpersonal and communication styles compatible with the general approach. Case management strategies relate to how the therapist relates to the social network within which the client is enmeshed. Integrative strategies relate to specific strategies about how to deal with specific problem situations such as suicidal behaviour or therapy interfering behaviour. Structural strategies have to do with how to structure therapy time.

In order to give a simple overview of DBT only the core strategies and the stylistic strategies will be elaborated.

Core Strategies

The core strategies of DBT are validation, problem solving and dialectical strategies.

Validation strategies: Invalidation is considered as a primary causative factor in the

development of BPD. Invalidation is also considered as an ongoing maladaptive behavioural response in a BPD client. Validation, as an antidote to these experiences is therefore judged to be a key therapeutic approach. Two types of validation are utilised in therapy.

The first type of validation comes from the therapist finding the “ wisdom” or “ correctness” in the client’ s emotional, behavioural, or cognitive response. The therapist comprehends that problems arise in an interdependent context. Thus therapist expresses that it is understandable that particular responses arise given the nature of environmental and other factors. Blame is not directed to the client and the variety of emotional and behavioural responses are acknowledged.

The second type of validation occurs when the therapist expresses the belief and the confidence in the client’ s inherent ability to resolve their problems and lead a worthwhile life.

Problem Solving strategies: These strategies involve the therapist helping the client to firstly define their problems and related contingencies. Then the therapist encourages the client to consider alternative solutions for their problems, apply solutions and finally evaluate the results. Depending upon the nature of the problem one of four types of change strategies may be needed.

1. If the client does not have the skills to deal with the problem these skills are taught. Usually the skills required are one of the types of skills taught in the skills training (group) modules. These are skills of mindfulness, interpersonal effectiveness, emotional regulation and distress tolerance.
2. If a problem is reinforced by a contingency factor, then this factor is altered. Here, positive behaviours are reinforced and the maladaptive behaviours are not reinforced and extinguished.
3. If a problem is related to excessive fear or guilt then it may be an anxiety type response. If so, this may be dealt with by utilising exposure-based treatments. Here

it is considered that talking about particular issues becomes a way to facilitate exposure. Acceptance and tolerance with mindfulness is considered as an exposure technique.

4. If a problem-solving behaviour is related to faulty beliefs and assumptions then cognitive modification or restructuring may be utilised.

Dialectical strategies: The aim of dialectical strategies involve avoiding being drawn into one side of an experience with the exclusion of the other. The aim is to balance extremes and find a synthesis. The reality and validity of both sides of an experience are emphasised. Here the primary dialectical approach is balancing change (problem focused strategies) with acceptance (validation strategies).

Dialectical strategies may also be directed at developing a dialectical perspective on phenomena. Paradoxical situations may be highlighted emphasising that a position is neither right or wrong, and that within any situation there are no absolutes. This may be confusing for the client but it is expected that this confusion will resolve or change by itself. These strategies may involve telling stories, metaphors or philosophising.

Stylistic strategies and the therapeutic relationship:

The therapeutic relationship is thought as paramount to DBT. In fact, in DBT it is considered that an intense caring relationship can bring about change. Similar to the benefits of transference in psycho-dynamic therapies a therapeutic relationship is considered as beneficial because it " allows the client to heal developmental deficiencies, stimulates innate potential for growth and fosters client autonomy" (Linehan, 1993, p.449)

Communication styles are the essence a therapeutic relationship. Stylistic strategies are related to the style and form of communication rather than the content. There are two basic communication styles with DBT. One is described as *reciprocal* and the other as *irreverent*. Consistent with strategies of validation the reciprocal style utilises warmth,

open responsiveness, appropriate personal disclosure and modeling. The irreverent style, on the other hand, is more direct, may use confrontation and may be abrupt. The therapist is never indifferent to a client's suffering, but they may express indifference to suicidal, therapy interfering and avoidance behaviours in a "matter of fact or 'off-the-wall' way" (Linehan, 1993, p.449). Such communication may be paradoxical and serve to not reinforce such behaviours. Like reciprocal communications and irreverent style and help the client to view these behaviours as understandable given the life circumstances of the client.

Types of treatment

The different types of treatment may involve individual treatment, telephone contact, case consultations for therapists and groups. Clients are contracted to participate in all aspects of the treatment for at least one year. DBT has some non-negotiable goals with which the client must agree. These are:

1. a commitment to decrease suicidal behaviour
2. a commitment to decrease behaviours that may interfere with therapy and quality of life (such as substance abuse, financial problems and other inappropriate life style behaviours)
3. a commitment to increase behavioural skills. (Linehan, 1987)

The groups and the individual psychotherapy support one another and are separately directed to the inter-related but specific needs of the BPD client group. The groups are primarily psycho-educational and are directed at developing skills. They also become a forum to practice, through interpersonal interaction, skills learnt. The individual sessions are directed at promoting change and provide an opportunity to process, and manage ongoing person specific issues (including crises) that commonly arise for these individual.

Individual Therapy (IT)

IT focuses upon motivational issues including the motivation to stay alive. IT occurs on a

weekly basis and may last anywhere from 50 to 90 minutes. Clients are required to complete daily behavioural diaries and bring these to the sessions. The agenda for the IT sessions is open and is contingent upon behaviours since the last session. Managing self harm behaviours are always the priority. The therapist is collaborative and is seen as " an educator, coach, cheerleader and consultant to the patient" (Koerner & Linehan, 1992, p446). The therapists assesses the client' s problems session by session and applies the problem solving, validation and dialectical strategies outlined above accordingly.

Telephone contact is an extension of the support given in individual therapy. It has a number of functions. For those who find it difficult to ask for help it becomes a way that clients can ask for help without feeling shame or guilt. For those who have no difficulty asking for help it may become, (according to Linehan, 1993) a way to practice altering dysfunctional behaviour such as being demanding or abusive. At times when a client is suicidal phone contact can support between sessions. Phone contact also help generalise skills learnt to daily life and give an opportunity to clarify misunderstandings or conflicts.

Case consultations are directed at the therapist so that they can maintain a dialectical perspective on their clients. This could be seen as a way of reducing " burn out" and is primarily " therapy" for the therapists. Having therapists engage in case discussion ensures that they do not develop pejorative attitudes about their clients and maintain positive regard.

Group skills programs

The groups are directed at developing specific skills that are thought to be deficient with the suicidal BPD population. The groups are psycho-educational in nature and the IT therapist may or may not attend these groups. However, unlike the IT sessions the skills sessions follow a set agenda and have strict rules. For example personal individual issues such as suicidal impulses, that may be discussed at the IT sessions are not

discussed in the skills group. If these issues arise the group co-ordinator refers the client to the IT therapist. Thus the group leader and IT therapist work in concert. Linehan (1993b) published a skills manual which elaborately details session by session outline, structure, format, content, and practical issues related to running these groups. These details will not be elaborated here suffice giving an very brief overview of the skills taught.

Mindfulness skills: are seen as central to DBT. They are over riding in the development of all the other skills. One of the rationales for practicing mindfulness is to develop a " wise mind" . Here the " wise" mind is emphasised as a balance between a " reasonable" intellectual, cold or rational mind and a reactive, hot, engaged " emotional" mind (Linehan, 1993b). The " wise" mind adds intuitive knowing to logical analysis and emotional experience. Mindfulness is explained as observing, describing and participating with experience. Thus it helps clients validate their emotional experience. Mindfulness is done in a manner that is non-judgmental, focused (or one thing at a time) and skilful. Present centred awareness or focusing on the present moment is an element of mindfulness. Linehan borrowed the rationale and the practice of this skill directly from Buddhist practices (specifically Hahn, 1976).

Interpersonal effectiveness skills: are rationalised as skills for dealing with interpersonal problems. The processes of training these skill are similar to the processes involved in teaching assertiveness skills.

Emotional Regulation skills: are directed at understanding emotions, reducing emotional vulnerability and decreasing emotional suffering. This involves learning to identify and label emotions, increase positive emotional events, create the opposite to negative emotions and manage distressing emotions with tolerance.

Distress tolerance skills: are skills directed at tolerating unavoidable painful events and

emotions. They involve learning skills of distraction, " self soothing" (comforting and nurturing) skills, " improving the moment" (relaxing and calming) skills and rationalising (" thinking about the pros and cons of a difficult situation") skills.

There are three types of skills training procedures: Skill acquisition, skill strengthening and skill generalisation. These procedures occur through instruction, modelling, behavioural rehearsal, feedback, homework and discussion. Like IT clients are asked to maintain a diary card. The content of the group skills dairy card involves noting the days particular skills were practiced.

Homework is checked at the beginning of each session. If homework is avoided then this is considered as a " therapy interfering" behaviour. Clients are permitted to miss up to three consecutive sessions but after this they are not permitted to rejoin the group. They are however permitted to renegotiate attending another group in the following six months (this flexibility is thought to enhance compliance).

The interpersonal effectiveness, emotional regulation, and distress tolerance modules each can be covered in 8 weeks and the mindfulness module can be covered in two or three sessions and is reviewed before the beginning of each other module. Thus, in the one year contracted, participants are able to attend each module two times.

Theoretical Perspectives.

DBT was developed from clinical experience. DBT has been described as an integrative or a hybrid therapeutic model (Albeinz & Holmes, 1996; Koerner & Linehan, 1992). DBT borrowed and integrated both its philosophical guiding principles and its treatment strategies from a variety of popular psychological theoretical views as well as a number contemplative spiritual traditions. Linehan argues, however, that DBT is not " atheoretical eclecticism" because it is guided by empirical support and dialectical and bio-social theories (Koerner & Linehan, 1992, p440).

Bio-social Models of BPD

The criteria for BPD can be found in the DSM-IV (American Psychiatric Association, 1994). Linehan does not disagree with the criteria found in the DSM-IV, but she considers that there may be a subset of BPD. This subset includes individuals who attempt to injure, mutilate, or kill themselves. Linehan considers that emotional dysregulation is the primary dysfunction of BPD (Linehan, 1993).

Secondary and interrelated to this Affect instability is:

- Behavioural instability with impulsive and suicidal behaviour,
- Interpersonal instability with chaotic and problematic relationships,
- Cognitive instability with occasional psychosis, dissociation and delusions, and
- Instability with the sense of self with a chronic sense of emptiness.

Linehan (1993) acknowledges that there are a number of models and proposed etiologies for the development of BPD. However, like Millon (1981) who was influential in developing the personality disorder criteria for the DSM systems, she emphasises bio-social theories and social learning influences in the aetiology of BPD. Linehan's bio-social model of BPD (1993) considered BPD results from an interactive and interdependent combination of biological predisposition and dysfunctional environments. Linehan's bio-social model "assumes that individual functioning and environmental conditions are mutually and continuously interactive, reciprocal and interdependent." (Linehan, 1993, p.39).

In Linehan's view, invalidating experiences and environments were crucial in the development of BPD. Predominate was the tendency for primary carers to respond inconsistently, erratically or inappropriately to private experience (such as emotions). Child sexual assault, which is a common experience for those suffering with BPD, is an example of one very powerful invalidating experience. As a result of invalidation, BPD individuals may have learnt to not be able to recognise, trust or modulate their emotions. Linehan (1993) claims that self invalidation continues to be a tendency with BPD clients. To counter this tendency DBT emphasises validation as a primary strategy.

According to the bio-social theory of BPD para-suicide it is a way of coping with psychic distress that has arisen due to negative environmental events, individual temperamental characteristics and other dysfunctional behaviours. Suicide attempts, as a dysfunctional coping strategy, has empirical support (Linehan, Camper, Chiles, Strosahl & Shearin 1987). According to Linehan's (1987) model, suicide attempts continue to be a coping strategy for the BPD as long as they are unable to tolerate distress, and they have poor skills in emotional regulation, interpersonal problem solving and self management. Thus, teaching and developing these skills along with being able to identify, understand and modulate emotions form a major component of DBT.

Popular treatment approaches

Treatment strategies found in Humanist and Psycho-dynamic paradigms are represented in DBT. Emphasising present centred (here now) awareness, balancing polarities, accepting oneself, and finding the inherent wisdom in each client are also found in Gestalt therapy (Fagan & Sepherd, 1971). Similarly therapeutic power of validation with genuiness, unconditional positive regard empathy are the primary factors of Carl Roger's client centred therapy (eg Rogers, 1961). In addition, corrective experiences, found with transference in the therapeutic relationship, have a history with psycho-dynamic therapies and can also be found in DBT

Behaviour Therapy is particularly utilised in DBT. With the BPD patient Linehan (1993) has organised a number of behavioural patterns that could be the target of treatments. These patterns include:

- Emotional vulnerability or a pervasive difficulty in regulating emotions;
- Self invalidation or a tendency to fail to recognise one's own emotional responses, thoughts, beliefs, and behaviours often resulting in secondary emotions such as shame, guilt, self hatred and self directed anger;

- Unrelenting crises often resulting from dysfunctional lifestyles;
- Inhibited grieving and a tendency to over control negative emotional responses;
- Active passivity which includes helplessness and hopelessness;
- Apparent competence or the tendency to appear more competent than they actually are thus failing to “ display adequate nonverbal cues of emotional distress” (Linehan, 1993,p.10).

In accordance with Behaviour Therapy, DBT focuses upon current behaviours, emphasises overt behaviour change, specifies treatment in objective terms and is specific about defining, treating and measuring target problems (Koerner & Linehan, 1992).

Dialectical Philosophies and theories.

The term Dialectical was incorporated in the name of the treatment because its meaning seemed, to Linehan (1993) to best describe her approach. Dialectics has two basic meanings. The first is where it involves reasoning and argument aimed at the clarification of the meaning of concepts. The second is where it involves the philosophy that reality is based upon and integration of opposites(Reber, 1995). Both these meanings are utilised with DBT. Persuasive dialogue in a relationship are strategies used to affect change. However, more importantly a dialectic world view is fundamental to the theoretical under-pinning and practice of DBT.

According to Linehan (1993) every theory of personality and its treatment is based upon a fundamental world view. The dialectical philosophical stance or world view and its concept of the “ self” permeates every aspect of DBT and directs how DBT therapists utilise therapeutic strategies and generally interact with the therapeutic process.

Lineham (1993) described a “ dialectical world view” which has three general

principles. The principles that Linehan utilised for the Dialectical view of reality and human behaviour are:

1. Humans (and in fact all conditions) are "interdependent" or essentially interrelated and part of a systemic whole,
2. Reality is not static but in a process of transformation "comprised of internal opposing forces (thesis and antithesis) of whose synthesis evolves a new set of opposing forces" (Linehan, 1993, p.33). Here it is considered that within each aspect of nature there is part of its opposite.
3. Reality, as a whole, is in constant process of change. Here the "process" of change rather than the content or structure is considered as "the essential nature of life" (Linehan, 1993, p.33).

The above three principles of life guide DBT treatment practices. Each principle is interdependent with each other. However, in order to elucidate DBT's theoretical underpinning and its connection with other paradigms these three principles will be considered separately.

1/Interdependence and Systems theories

It is generally considered that most western psychology has been based upon independent self concepts and world views (Gergen, Gulerce & Misra, 1996).

The self described as independent is an autonomous entity that consists of unique internal attributes, such as values, abilities and motives. This self is characterised by clear and distinct boundaries between self and other. Treatment strategies incorporating independent self concepts value control, competition and achievement (Perloff, 1987; Spence, 1985; Weisz, Rothbaum, & Blackburn, 1984).

The interdependent self is described contextually and socially. Behaviour is determined contingent upon contextual factors such as environmental conditions and the thoughts feeling and actions of others. In contrast to approaches that incorporate independent self concept those that involve interdependent self concept value co-operation,

interdependence and accommodation. With this self concept the self's boundaries are fluid, indistinct and interactive (Markus & Kitayama, 1991)

Treatments that are based on independent self construals such as CBT generally adopt linear causality to explain pathology and the treatment of pathology. CBT, for example, adopts the "ABC of thinking" to rationalise how distorted thinking patterns (B) may mediate negative emotional consequences (C). With treatment modalities that adopt linear causality "A" leads to "B" leads to "C". If "C" is a problem then it can be resolved by changing "B" or "A". With interdependent notions of causality "A, B, and C" are interdependent. If there is no "B" then "C" does not arise. However, as "C" is part of system that cannot be separated from the whole, the arising or nature of "A" is dependent upon the nature of "C" or "B". In other words, the interdependent co-arising of self and the world (represented by A B and C) are reciprocally modified by their interaction.

Popular theoretical views such as Symbolic Interactionism (Mahoney, 1992), Feminism (Steen, 1991), or General Systems Theory (Nichols & Everett, 1986) could be described as interdependent. Spiritual traditions such as Buddhism and Taoism could also be described as being based upon interdependent world views and notions of the self (Macy, 1991).

In Buddhism "emptiness" is considered as a characteristic of existence. In Buddhism "emptiness" means that conditions are "empty" of self existence. According to systemic Buddhist principles, phenomena or "things" cannot be seen as "things" in and of themselves. They are in fact "empty" of self existence because they depend on other factors for their arising and passing.

Emptiness or interdependence of existence is reflected in the practice of DBT by the way it does not encourage blame or finding original causes for suffering. Instead, clients are encouraged to be aware of the interdependent nature of their experience. By

directing mindfulness to the interdependent nature of their condition, highly emotional borderlines may begin to not identify with their extreme emotions. Rather, they may begin to be aware of contingencies or cause effect relationships between conditions and possibly develop acceptance and tolerance.

2/Principles of polarity and Transformations

Dialectical philosophies are based upon principles of polarities and transformation. Though Linehan (1993) does not acknowledge Taoism it is perhaps the oldest dialectical philosophy dating over 5000 years. An explanation of Taoism may help explain the dialectical basis of DBT. Taoism is founded upon the theory of Yin and Yang. Yin Yang theory has been popularised in modern culture and the Yin Yang symbol which represents its meanings can be found in most parts of our modern community.

Yin/yang sign here

The circle is symbolic of the interconnected wholeness of phenomena. Within this circle the two symbolic opposites (here black and white) are defined by their nature, their position and their relationship to each other. One thing cannot exist separately from its opposite and within each extreme there is part of its opposite (black within white and vice versa). The movement shown in the symbol represents that the opposite aspects of Yin and Yang are always subtly transforming to each other. Yin and Yang can

represent any aspect of life including mental and physical conditions.

Yin Yang theory forms the basis of Traditional Chinese Medicine. Health in this system is considered as a harmonious balance between the Yin and Yang where regular transformations occur smoothly. Ill health is considered when the Yin and Yang aspects are unbalanced. With ill health transformations will eventually occur but when they do they are extreme and drastic (Kaptchuk, 1983). Linehan (1993) has adopted this practical philosophical perspective to help explain the nature of and treatment of a BPD client's suffering.

Extremes of emotions, instability, and dramatic transformations are characteristic of a BPD client. They may have dramatic mood swings often resulting in unhealthy maladaptive behaviours. In addition, according to Linehan, (1993) the BPD client is often caught in dialectical dilemmas, confused about what orientation to adopt to rationalise their suffering and explain the world. They may travel between two extreme positions related to their behaviour such as the extremes of vulnerability and invalidation. For example, at one extreme they may feel that they are bad, weak, useless etc and passionately invalidate themselves. At another extreme they may validate their vulnerability, not seeing the cause effect relationship between conditions but feel that whatever negative things that may happen to them are totally unfair and should not be happening.

Some of the targets for DBT are to help the BPD client develop the skills to regulate their emotions and stabilise their behaviours so that the natural transformations of emotions and actions may be " healthy" . Linehan (1993) also suggests that patience, acceptance, self compassion, life style management and self soothing are ingredients and the outcome of the synthesis of vulnerability and invalidation.

Yin Yang theory has a principle of polarity. DBT has adopted this principle. This means for a BPD client that within chaos there is clarity, within dysfunction there is

function, and within distortion accuracy. Like "emptiness" in Buddhism, things cannot be defined without their opposites. For example, the term "hate" is meaningless unless "love" helps to define it, and there is no "good" without "bad". To extend this further DBT clients are encouraged to understand that there are no absolutes as conditions will always change. Even in the most bleak and desperate experiences the opposite of hope is always possible. The DBT therapist reflects this "theoretical" understanding by never expressing disregard and hopelessness about their clients. Rather, the therapist expresses confidence that their clients can understand and resolve their own problems.

3/The process of Change

All things that arise due to interdependent conditions are also subject to decay as these conditions inevitably change. The impermanent nature of existence is the third principle of DBT. Change seems an obvious condition of reality yet accepting this reality can be difficult and fraught with struggle and suffering. One sub-goal of DBT is to help clients understand the nature of change with acceptance and tolerance.

Change is also one of the three characteristics of existence found in Buddhist philosophies (the other two being being "emptiness" and "unsatisfactoriness"). For Buddhists the antidote for struggle is acceptance of the way things are or the truth. It seems that of all the spiritual traditions DBT has borrowed and adapted most heavily from Buddhism. In fact, there are so many parallels between DBT and the meditative practice of Buddhism that a brief explanation of Buddhist theories and its relationship to DBT may help elucidate the driving philosophical underpinning of DBT where "change" is an important principle. This explanation may also help clarify why acceptance and distress tolerance are two very important strategies employed with DBT.

Buddhism and DBT

The four noble truths drive Buddhist theory and practice. These truths are:

1. that there is unsatisfactoriness or suffering ,
2. there is an interdependent causality for suffering,
3. there is the possibility for freedom from suffering and
4. there is a way or a path to freedom.

Buddhists believe, through their observations and experience, that all conditioned phenomena is impermanent, there is no " soul" and there is not part of mind or body that lasts. If all conditions are impermanent fulfillment and satisfaction based upon these changing conditions cannot be found (the 1st noble truth). Sometimes conditions are pleasant, sometimes they are unpleasant and sometimes they are neutral. According to Buddhists the more one is attached, adverse or ignorant about the nature of changing conditions the more one will suffer. Thus struggling and resistance to inevitable change and wanting things to be other than " the way things are" are interdependent factors (the 2nd noble truth) leading to suffering. Freedom from this suffering is possible (the 3rd noble truth) but paradoxically this is a frame of mind that is content with the things as they are. This " contentment" occurs by developing understanding or " wisdom" and practicing according to this understanding (the 4th noble truth). Thus, non-attachment is developed when conditions are pleasant and acceptance and tolerance when they are unpleasant .

The first noble truth of suffering can include all dimensions of mental distress that a BPD individual may experience. Consistent with popular systemic theories, the cause of this suffering, in Buddhism is seen as an interdependent relationship between environmental conditions and " unhealthy" mental and physical factors. Release, or resolution of suffering is possible but this also seen to arise from an interdependent relationship between environmental conditions and " healthy" mental and physical factors. The generation of the environmental conditions and the mental and physical factors necessary for liberation from mental suffering is called the noble eight fold path. The noble eight fold path is the essential practice of Buddhism.

The eight factors on the Buddhist path can be divided into three basic components being ethics or lifestyle ("right" or skilful action, speech, livelihood,), mental development (right effort mindfulness and concentration) and wisdom (right understanding and thought or intention).

The main DBT therapeutic factor that Linehan attributes to Buddhism is "mindfulness". However, other factors on the eight fold path including skilful lifestyle, concentration, and wisdom are also part of DBT's therapeutic factors. Linehan (1993) places mindfulness central in regulating, managing, tolerating, distressing emotions as well as processing past trauma. She considers mindfulness practice this similar to exposure where the acceptance of a difficult situation can lead to extinction of reactions and change.

The function of mindfulness in Buddhism is multifaceted. In addition to being as a tool for exposure, mindfulness is considered as a mental factor that can reciprocally inhibit unhealthy mental factors. The core unhealthy mental factors are attachment, aversion and ignorance (ignoring the way things are) (Goleman, 1989). According to Buddhists Mindfulness helps to bring perceptions in line with the "truth". Acceptance and tolerance often result from mindfulness. Acceptance and tolerance allow conditions to change according to nature and they do not reinforce the factors of attachment or aversion. Like DBT distress tolerance, acceptance or "accommodating" difficult situations are core features of Buddhist practice.

Both Buddhism and DBT have an insight or "wisdom" component, but "understanding" supports and is supported by changes in overt behaviours. In order decrease the unwholesome mental factors and reduce maladaptive behaviours simple behavioural principles found in Behaviour Therapy are also applied in Buddhist practices (De Silva, 1986). Thus like DBT, Buddhism also balances the dialectic of acceptance and change.

Other practices found in both Buddhism and DBT include the therapeutic utilisation of loving kindness and compassion and the communication styles (both reciprocal and irreverent) that may express this (personal experience with meditation teachers). In fact, it seems that with DBT Linehan (1993) has adapted many of the practices and philosophical principles found in Buddhism to the unique problems found with BPD.

Empirical Evidence and Support

The term "empirical" has a number of meanings. At its most basic level empirical evidence is evidence that is based upon experience as opposed to theory (Reber, 1995). Empirical support for an intervention procedure can have a number of levels. Psychologists generally consider that evidence derived from controlled studies has a higher level of validity than evidence from uncontrolled studies. Nevertheless, the latter in the form of, for example, anecdotal reports is still relevant.

There is a paucity of controlled empirical evidence related to successful treatments for BPD (Roth & Fonagy, 1991). This is possibly because BPD's difficult treatment targets and if treatment is undertaken it is usually very timely.

As mentioned previously the target goals of DBT are:

- 1/ reduction of suicidal behaviours
- 2/reduction of therapy interfering behaviour
- 3/increase in quality of life
- 4/increase in coping skills in clients with a BPD diagnosis.

There is empirical support for the use of DBT as a program to influence these target goals. Empirical support can also be considered when the separate components of DBT are analysed independently.

The components of DBT considered separately .

The components of DBT basically consist of problem focused strategies, validation strategies and strategies based upon dialectical philosophies. If the variety of therapeutic components that have come together to create DBT are analysed separately there is an abundance of empirical evidence to support their use for some of DBT's target goals.

The strategies utilised for the problem focused cognitive and behavioural therapies has a history of both higher and lower level evidence that supports their use with maladaptive behaviours including cognition. " The core treatment procedures of problem solving, exposure techniques, skills training contingency management and cognitive modification have been prominent in cognitive and behavioural therapy for years. Each set of procedures has an enormous empirical and theoretical literature" (Linehan, 1993, p19).

The validating components of Roger's (1961) Client Centred Therapy that include the personal attributes of the therapist also have a history of empirical evaluation. Though Roger's phenomenological approach to research has been criticised it is generally accepted that the therapist qualities of genuineness, congruence and empathy have therapeutic value and empirical support (Davison & Neale, 1982).

Linehan emphasised that the dialectical world view that permeates the practice of DBT " Can be neither proved nor disproved" (Linehan, 1993, p.64) because it is a philosophical position. However, empirical support for this view could be analysed by considering the impact of systems of practice that are aligned with it. The meditative practices of Taoism and Buddhism to promote mental health, for example, have survived thousands of years and continue to grow in popularity. It is claimed that the Buddha (founder of Buddhism) said that the practice that one chooses to reduce suffering must be based upon personal experience and not theory (Rahula, 1987). The continued popularity and support of systems such as Buddhism could, to a large degree,

be based upon individuals' personal experience and the experiential validation that strategies incorporated may improve a practitioner's quality of life.

DBT as an integrated program

It seems that the empirical support for DBT as a program comes primarily from one controlled clinical trial in 1991 (Linehan, Armstrong, , Suarez, Allmon, and Heard, 1991). Most subjects from this trial were also followed up 18 and 24 months later (Linehan, Armstrong, & Heard, 1993).

Most of the other evidence supporting the use of DBT comes from related studies and anecdotal reports from clinicians and patients. It should be noted that all the studies related to DBT have only occurred with female subjects.

In the first clinical trial 47 suicidal women who fulfilled criteria for BPD and had been suicidal were randomly assigned to either, DBT or treatment as usual (TAU) groups (Linehan et al., 1991). The treatment period lasted one year and at the end of the year 41 subjects remained (DBT=20, TUA=21). Subjects were assessed at 4, 8 and 12 month (post treatment) intervals.

Results on measures for the DBT group were significantly different than the TAU group. The DBT group were less likely to perform a parasuicidal attempt. They were significantly more likely to stay in therapy (ie not drop out of treatment), and the DBT group had significantly less presentations to hospital. However, the results for self reports of hopelessness, suicidal ideations and reasons for living were not significantly different between the two groups.

At 18 month follow up Linehan et al., (1993) assessed 37 subjects and at 24 months follow up they only found and assessed 35 subjects. These subjects were given scales and interviews that assessed para-suicidal behaviour, psychiatric in-patient days, anger, global functioning and social adjustment At the 18 month follow up the DBT subjects

reported significantly less anger and better social adjustment than the non-DBT subjects. At the 24 month follow up the DBT subjects rated significantly higher on overall social adjustment.

In a related study Linehan, Tutek, Heard and Armstrong (1994) examined the effects of DBT on interpersonal variables with subjects diagnosed with BPD. In a similar manner to the Linehan et al., (1991) study 26 subjects who were suicidal and fulfilled criteria for BPD were randomly allocated to either to DBT or TAU and were assessed at 4, 8 and 12 month (post treatment) intervals. The DBT subjects rated themselves significantly better on trait anger scores and overall social adjustment. Interviewers also rated the DBT subjects significantly better on a Global Assessment Scale and global social adjustment. There were, however, no significant differences in general patient satisfaction at the one year assessment.

The three studies outlined above indicate that DBT may be effective in changing target behaviours but the lack of difference in depressive symptoms and levels of satisfaction indicate that despite DBT all subjects still felt miserable at the end of treatment.

One very small study (therapists = 4 and patients = 4) investigated the influence of the patient therapist relationship with DBT in reducing suicidal behaviour (Shearin & Linehan, 1992). The results indicated that dialectical techniques that balanced change and acceptance were more effective than an emphasis on change or acceptance alone. Less suicidal behaviour was also more consistent with the therapist being non-pejorative.

In another very small study the effects of the skills group was considered (Linehan, Heard, & Armstrong 1993 in Linehan, 1993). In this study BPD with suicidality who were receiving non DBT treatment in the community were randomly chosen to also attend a DBT skills group (N=11) or not attend a group (N=8). The results suggested that the addition of the skills group added little to the non-DBT individual sessions.

All of the studies outlined above give empirical support for the use of DBT for some target behaviours. The major criticisms of these studies, are:

- that there are only a few controlled studies,
- the studies that have occurred were only very small and therefore lacked statistical power

- there are no known independent controlled studies. All the controlled studies have been conducted by Linehan and her associates.

In defence of these criticisms it should be noted that controlled studies related cognitive and behavioural approaches to the treatment of BPD are very small in number. Ver Der Sande et al., (1997) claimed that there were only four. Of these four studies the Linehan et al., (1991) was the only study that indicated a treatment package could result in a reduction suicide behaviour that was maintained at follow up assessment times.

Adaptations of DBT

There are no known independent controlled trials of the DBT program. However, there has been a number of documented adaptations of the DBT program. DBT seems to be adaptable to a variety of settings and run by different professionals. Simpson , Pistorello, Begin, Costello, Levinson, Mulberry, Perlstein, Rosen, and Stevens (1998) claimed that DBT could be effectively modified for a partial hospital setting and diverse population. They based their statement on two years of utilising aspects of DBT to a setting that received female BPD patients as well as other women who experienced a number of co-morbid disorders. They claimed that anecdotal evidence from staff and patients was " promising" and they planned to conduct controlled research.

Simpson et al., (1998) cited one study where DBT had been adapted to an inpatient settings (Barely et al., 1993 in Simpson et al., 1998). Details of this study were lacking nevertheless they claim that in it a psycho-dynamic inpatient unit emphasised the substitution of DBT skills for dysfunctional emotional dyregulation. The program noted a decrease in the incidence of para-suicide. In another other inpatient setting (Miller, Eisner & Allport, 1994; Silk et al., in Simpson et al., 1998), BPD patients were allocated to a control group or a " creative coping" group based upon DBT. The group based on DBT demonstrated confidence that the skills learnt would be effective to cope with self destructive urges and emotional pain. In this setting it was also noted that

previously frustrated nurses felt empowered because they no longer felt in a reactive position. Rather, they felt that they were able to offer the development of helpful skills and were more willing to engage the patient.

Evaluating Comments and Conclusion.

The following comments about DBT are based only upon reviewing the literature. They are limited by having not done a training (which is presently available in Australia) or practiced DBT as a program.

The paradoxical and dialectical nature of DBT can be extended to its evaluation. Evaluating statements of an absolute nature cannot be made as they are relative and dependent upon the standards and position from which the evaluation is made. It seems that as an empirically supported package for use with suicidal BPD clients, DBT has possibilities but there are limitations. However, when DBT is considered as a model of intervention from which therapists can adapt to a variety of settings and presentations the possibilities are many.

DBT as a program

Linehan (1993) boasts that DBT is evidence based and review articles referring to DBT consider it in a positive manner because it is supported "empirically" (eg Holmes, 1995; Roth & Fonagy, 1996; Scott, 1995). However, when the empirical evidence is analysed (as above) it is meagre. It is acknowledged that BPD and its treatment are not easy targets for controlled independent studies. However, perhaps more studies are needed before therapists become too excited.

One limitation of DBT as a package is that it seems exclusive. Linehan (1993) emphasised throughout her manual that therapists need to be aligned with the dialectical philosophy to successfully practice DBT. To this end the therapist consultations are mandatory. In addition, in reference to the Buddhist practice of

mindfulness she states " it is not possible to conduct DBT without an inner understanding of this practice" (Linehan, 1993, p.525). Even though mindfulness is a non-religious skill and an interdependent view is not limited to Buddhism it seems that therapists who have an independent self concept or a theistic view of the world may feel excluded from DBT practice

The same sense of exclusion could be extended to the BPD clients. With respect to cultural relativism, treatment strategies need to adapt to a client' s worldview (Ivey, Ivey, & Simek-Morgan, 1993). The practice of DBT includes " educating" the client about the dialectical world view. For many clients this process could be difficult and inappropriate because it may oppose their fundamental world view. Clients may resist, for example, being open to concepts such as a " non-judgmental" attitude about emotions or the development of a " wise" mind. Such concepts may be culturally alien regardless of the rigid mind sets that may be found with BPD.

Another limitation of DBT as a program is its possible complexity. Many strategies found in DBT have been particularly inspired by Zen Buddhism. Zen Buddhism is one of the many different Buddhist traditions and is renown for its simplicity. Often instructions from Zen masters may be as simple as " Just This, Here Now" because proliferation is considered as suffering (personal experience with Zen master Hogan Yamahata). Ironically, Linehan' s (1993) DBT is prolific with concepts, rationales, targets, tasks, requirements and strategies. This complexity may confuse and discourage clinicians as well as clients from attempting to understand and apply DBT. In addition, the proliferation of concepts may make dialectical philosophies and their practices, which in their essence are very simple, seem more complex than they actually are. The skills training manual contains over eighty pages of handouts and homework tasks. A level of intellectual sophistication may be required to integrate and synthesis the bulk of complex information involved. For many clients this process may be baffling. In reference to Linehan' s text (1993) and Skills manual (1993b) that explain the theory and practice of DBT Scott, (1995) thought that text exemplified Linehan and her

team' s rich clinical experience and wisdom but that the inexperienced clinician should not attempt to implement the package without training.

DBT as a model to adapt from.

Paradoxically, the complexity that could be an obstacle for some therapists and clients could, for others, be source of inspiration. Despite the need for training Scott (1995, p.650) thought that these volumes were a valuable resource with a " wealth of useful information" about the concept of BPD and how it could be successfully treated. Similarly, Hampton (1997) like Simpson et al. (1998) considered that DBT can be empowering for therapists because it offers treatment approach that seems to work. The BPD client is often considered as incorrigible and have " been stigmatised as ' problem patients'" (Hampton, 1997, p.100). DBT can give a sense of direction and empirically validated hope.

DBT can be adapted to those situations where the full package cannot be applied. For example, in a workshop about the management of BPD, Jillian Ball, (1996) referred to DBT and described how behaviour diaries, activity scheduling, limited telephone contact and strict contracting can be helpful with the suicidal BPD clients.

For therapists who may already operate from an interdependent world view, DBT is an example of how numerous validated traditional psychological approaches can be blended with interdependent philosophies such as Buddhism. Such an approach need not be limited to BPD but could be adapted to other co-morbid disorders, such as depression where validation, a cognitive and behavioural approach and dialectical philosophies may be appropriate.

Summary

In summary, DBT is a program package that has been developed for the treatment of suicidal BPD women. It has been based upon dialectical philosophies, a bio-social theory of BPD and a number of popular psychological approaches especially Behaviour

Therapy. Empirical evidence is meagre but it is still valid and relative to other evidence related to the treatment of suicidal BPD clients, it is substantial. DBT as a package skilfully blends a number of approaches but from one angle it may seem exclusive and complex. From another angle it provides hope and a model of treatment for suicidal BPD clients in a variety of settings. From yet another angle DBT provides a resource from which therapeutic ideas can be adapted.

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