Dialectical Behavior Therapy: A Feminist-Behavioral Treatment of Borderline Personality Disorder

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This is the third in a series of articles on women's issues, presented by the Women's Issues in Behavior Therapy Special Interest Group. In this article, Marsha Linehan and Amy Wagner discuss dialectic behavior therapy, a feminist-behavioral approach for treating clients with Borderline Personality Disorder. Borderline Personality Disorder typically begins by early adulthood and is diagnosed in women more often than in men (American Psychiatric Association, 1987). The authors present a theory of Borderline Personality Disorder and a treatment program for helping Borderline clients. Some aspects of this treatment program are common to other types of behavior therapy, while other aspects are drawn from other sources such as feminist therapy. For example, dialectic behavior therapy emphasizes the client's invalidating environment, similar to the way that feminist therapy emphasizes the client's sexist environment that makes incompatible and contradictory demands on women. This article will be useful to therapists who see female Borderline clients and who want to use a treatment approach that is both behavioral and feminist.

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Borderline personality disorder as an official diagnostic category is relatively new, appearing first in the third edition of the DSM (APA, 1980). Its history, however, is quite lengthy within the psychoanalytic community. The term was first used by Adolf Stern in 1938 to describe a group of out-patients who, in the view of analysts, did not profit from classical psychoanalysis and did not seem to fit into the then standard neurotic or psychotic psychiatric categories. The current diagnostic criteria according to DSM III-R (APA, 1987) are characterized by four types of pervasive instability: interpersonal, affective, behavioral, and self-concept.

Diagnosis necessitates the presence of five of the following eight conditions listed in the DSM III-R: (a) a pattern of unstable and intense interpersonal relationships; (b) frantic efforts to avoid real or imagined abandonment; (c) marked shifts from baseline mood to depression, irritability, or anxiety, usually lasting a few hours; (d) inappropriate, intense anger or lack of control of anger; (e) impulsiveness in at least two areas that are potentially self-damaging; (f) recurrent suicidal threats, gestures, or behavior, or self-mutilating behavior; (g) marked and persistent identity disturbance; and (h) chronic feelings or emptiness or boredom.

Among behavior therapists, diagnostic categorization in general is controversial. This has especially been the case for Axis II (personality disorder) diagnoses. We share these concerns as well (see Linehan & Wasson, in press, for a review of this issue). None-theless, behavior therapists are showing a slow but steady upsurge of interest in the behavioral patterns associated with borderline personality disorder. Applications of both cognitive and behavioral theories and treatments directed towards individuals meeting criteria for borderline personality disorder have been proposed at professional meetings (Barley, 1981; Linehan, 1984, 1985, 1986, 1987a; Padesky, 1986; Turner, 1984, 1987; Young, 1983, 1988) and in the literature (Linehan, 1987b, 1987c, 1987d, 1987e; Linehan & Wasson, in press; Pretzer, in press; Turner, 1983; Young, 1987).

Borderline personality disorder is a diagnosis given primarily to women (APA, 1987). Interestingly, most major psychoanalytic (e.g., Adler, 1985; Gunderson, 1984; Kernberg, 1984; Masterson, 1976), cognitive (e.g., Young, 1983, 1988), and behavioral (e.g., Turner, 1987) theories and treatments for this disorder have been developed by men. Many psychologists would agree that psychotherapies are based on implicit value systems (Halleck, 1971). In our view it is possible that theories and therapies proposed by men for borderline personality disorder are based at least implicitly on "male developed norms," inadequate for conceptualizing the problems of borderline women (Rosewater & Walker, 1985).

A major exception is the behavioral theory and treatment model proposed by the first author (Linehan, 1987c). Certainly, much of her treatment is based on traditional (i.e., male-developed) behavior therapy techniques. However, her theory and orientation are decidedly feminist. The major organizing position of Linehan is that of dialectics, a term to be discussed later. As we shall see, this dialectical philosophical orientation is fundamentally compatible with feminist values. The purpose of this article is twofold: to describe Linehan's theory and treatment and to compare her approach with more traditional therapies.

Theoretical Stance

Linehan's theory is based on a dialectical philosophical orientation and combines both diathesis-stress and learning models of psychopathology. Although every attempt has been made to base the theory on known empirical data, a major focus was to

create a theoretical stance that would help the clinician work effectively with the borderline client. Some data suggest that borderline clients who are liked by their therapists do better in treatment than those who are not liked (Stone, Stone & Hunt, 1987; Woollcott, 1985). In the theory presented below, Linehan made a conscious effort to create a theory that will enhance therapists' compassion and liking for their borderline clients.

Dialectics

A dialectical approach has been applied to socioeconomic history (Marx & Engels, 1970), the development of science (Kuhn, 1970), biological evolution (Levins & Lewontin, 1985), analyses of sexual relations and feminist therapy (Adams & Durham, 1977; Firestone, 1970), and more recently to the development of thinking in adults (Bassechus, 1984). Wells (1972) has documented a shift towards dialectical analyses in almost every social and natural science during the last 150 years. This shift is quite compatible with behavioral approaches as it involves a shift from entity to process, from static to dynamic, and from dichotomous to dimensional (Kegan, 1982). Most important, a dialectical approach to psychopathology may allow greater compassion. Dialectics, with its emphasis on developmental and inclusive/systemic accounts of change, is incompatible with the assignment of blame.

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A dialectical approach emphasizes interconnectedness, wholeness, and process (change) as fundamental characteristics of reality. All things are seen as inherently heterogeneous, comprised of opposing forces (the thesis and antithesis). Change is a characteristic of all systems and occurs through the interaction of opposing forces. The whole, then, is much more than the sum of its individual parts; it is a dynamic system maintained by the temporary balance of its opposing parts. At the same time, the ever-changing nature of the whole influences and is influenced by the external world of which it is, in turn, a part (Linehan & Wasson, in press).

This perspective influences conceptualization on all levels. For example, a dialectical view favors a systems approach. Within the behavioral, tripartite systems view of human functioning (Staats, 1975), a dialectical orientation suggests that the relationships among the three systems (overt/motor, physiological/emotional, cognitive/verbal) are dynamic and reciprocal, such that change in any one will produce system-wide changes. Addressing one system in isolation from the others, therefore, is not meaningful. In turn, the individual cannot be isolated from his or her environment. Less obvious, but equally true, the environment cannot be isolated from the individual.

The overriding opposition accounting for the genesis of the borderline syndrome may be the juxtaposition of an emotion invalidating environment and a physiologically predisposed vulnerability to emotional extremes. Similarly, current behavioral patterns among borderline individuals can often be analyzed in terms of the influences of contradicting beliefs, conflicting functional outcomes across poorly differentiated environments, and/or incompatible response repertoires.

From our point of view, a fundamental dialectic in any psychotherapy, including behavior therapy, is that change can only occur in the context of acceptance of reality as it is. And, acceptance is fundamentally linked to the possibility of change. Dialectical behavior therapy utilizes the dialectical tensions and oppositions that exist within the therapeutic environment to promote change in the borderline client. The focus on dialectics guides the therapist in balancing change versus acceptance strategies in the treatment setting. In addition, a dialectical approach focuses therapeutic attention on the client's difficulties thinking dialectically (i.e., the client's rigid and dichotomous thinking), synthesizing conflicting response patterns across time and situations, and integrating personal needs with environmental demands. Some examples of this process will be given throughout the article.

Behavioral Patterns

Linehan's theory incorporates a description of behavioral syndromes characteristic among adults meeting the borderline criteria, with an analysis of their associated temperamental and developmental patterns. These behavioral patterns can be organized along three dialectical poles arranged around a biosocial axis: (a) emotional vulnerability versus invalidation, (b) active passivity versus the apparently competent person, and (c) unrelenting crises versus inhibited grieving. From a theoretical stance, those patterns on one side of the axis (emotional vulnerability, active passivity, unrelenting crises) are originally most heavily influenced by biological factors associated with emotion regulation. Those patterns on the other side of the axis (invalidation, apparently competent person, inhibited grieving) are most heavily influenced by social responses to emotional expressiveness.

Emotional vulnerability vs. the invalidating syndrome. Emotional vulnerability refers to the inability of many borderline clients to regulate emotional responses. They appear excessively sensitive to any kind of stimuli, respond intensely to even low-level stimuli, and have difficulty regulating the return to emotional baseline. From Linehan's theoretical viewpoint, this emotion regulation dysfunction is most likely physiologically based and is a core characteristic of the borderline disorder. This emotional vulnerability leads to a pattern of vacillating between avoiding and/or inhibiting all incoming emotional stimuli and intensely overreacting to current emotional stimuli. Suicidal behaviors are usually maladaptive responses to overwhelming, uncontrollable painful negative affect. Empirical data support a physiological basis of emotion regulation. In particular, research on temperament suggests that high autonomic and emotional reactivity is often constitutional in origin (Derryberry & Rothbart, 1984; Strelau, Farley, & Gale, 1986; Thomas & Chess, 1986). Cowdry and his associates (cf. Turkington, 1986) report that borderlines may have a low threshold for activation of limbic structures, a brain system associated with emotion regulation.

The invalidating syndrome refers to the tendency to invalidate affective experiences and to oversimplify the ease of solving life's problems. Often, significant others in these clients' lives do not tolerate any display of negative affect, dismissing or trivializing both the experience of painful emotions as well as the factors these clients view as causative. The nonacceptance or oversimplification of the original problem precludes the kind of support and diligent training such individuals need. As a result, they do not learn to adequately label, control, or trust their emotional reactions. Often they learn that extreme emotional displays are necessary to provoke a helpful envi-

ronmental response. In addition, they learn to respond to their own emotional reactivity as their environments have modeled—with shame, criticism, and punishment, together with attempts to inhibit all negative emotional experiences and expression.

Empirical support, except for clinical observations, for the invalidating syndrome is meager. However, the work with expressed emotion in families of both depressive and schizophrenic families suggest that such a family constellation can be extremely powerful with the vulnerable individual (Leff & Vaughn, 1985). In addition, Perry and Cooper (1986) report a strong association between borderline personality and blind psychiatric ratings of conflicts over the experience and expression of emotional needs and anger.

The juxtaposition of an emotionally vulnerable temperament with an invalidating environment has important implications for understanding the suicidal behavior of borderline individuals. Recognition of the discrepancy that exists between one's capacities for emotional and behavioral control and the excessive demands and criticism by the environment can lead to both anger and attempts to elicit understanding and validation from others through dysfunctional (suicidal) behavior. Such behavior is especially likely, of course, when the environment responds in a compassionate and helpful manner only to extreme expressions of distress, a characteristic of invalidating interpersonal environments.

The strong influence of an invalidating environment coupled with difficulties in regulating emotion suggest a treatment based on validating strategies and on teaching emotion regulation skills. A major portion of dialectical behavior therapy is devoted to teaching a variety of widely recognized cognitive and behavioral techniques to achieve this end, including the following: *emotion regulation,* which involves problem-solving strategies for reducing vulnerability to stressful situations, as well as the characteristic overwhelming affective responses to these situations; *interpersonal effectiveness,* including coping skills necessary to solve interpersonal problems; *distress tolerance,* which utilizes a combination of behavioral strategies to delay gratification and control impulses, cognitive strategies to teach the acceptance of life as it is, and Eastern mediation to teach practices such as "mindfulness"; and finally, a variety of *self-management skills.* Furthermore, the therapeutic setting is designed to promote a validating environment, whereby new behaviors can be practiced without fear or the threat of punishment.

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Active passivity vs. the apparently competent person. The defining characteristic of the active passivity syndrome is the tendency to approach problems passively and helplessly rather than actively and competently. There is also a corresponding tendency under extreme distress to demand active problem solving by the environment. It is not uncommon, for example, for borderline clients to call their therapist in extreme emotional states, demanding that the therapist do something to relieve their pain before they resort to suicide. However, such clients are often very reluctant to put the therapist's suggestions into practice. Passive problem solving can best be understood as a learned helplessness patern, although it may have biological roots as well. Eliasz (1985) found that people with high autonomic reactivity often prefer passive self-regulation styles. Borderline individuals are aware of their frequent inability to interact successfully despite their best effort and thus stop trying. In addition, in an environment where difficulties are minimized, one learns to magnify them so that they will be taken seriously. The individual balances nonrecognition of inadequacy by others with extreme inadequacy and passivity. The inability of borderline individuals to solve their own affective and interpersonal problems leads them to actively reach out to others for problem resolution. Empirical support for this behavioral pattern can be found in work on both parasuicidal and borderline individuals. In our research, inpatient parasuicidal individuals, compared with both suicidal and nonsuicidal psychiatric inpatients, show markedly lower active interpersonal problem solving (Linehan, Camper, Chiles, Strosahl, & Shearin, 1987). Perry and Cooper (1985) report an association between the borderline personality disorder and low self-efficacy, high dependency, and emotional reliance on others.

These behavior patterns are in marked contrast to the "apparently competent person" syndrome, the tendency of borderline individuals to appear deceptively competent, both interpersonally and in other ways. The deception is that real competencies are not generalized across all relevant situations and are often intertwined with many incompetent behavior patterns. The appearance of total competence can fool others into believing these individuals are more competent than they actually are. An inability to synthesize the notions of both competence and incompetence, of control and noncontrol, of needing and not needing help can lead to dysfunctional behaviors, including suicide and parasuicide, aimed at reducing the painful (contradictory) emotional states.

The dimension of active passivity *versus* the apparently competent person can lead to great difficulties in therapy. Therapists responding to competency expectancies may be unresponsive to low-level communications of distress and difficulty, thus taking on the characteristics of the invalidating environment. In contrast, if therapists do not recognize clients' true capacities, they may fall into the active passivity pattern with their clients. The therapist's role is to balance the client's capabilities and deficiencies, flexibly alternating between supportive-acceptance and confrontational-change approaches to treatment. On one hand the therapist recognizes and validates the client's reactions to life's difficulties, yet on the other hand works to change those reactions.

Unrelenting crises vs. inhibited grieving. Many borderline and suicidal individuals are in a state of perpetual emotional crisis. This state of crisis is debilitating, not because of the magnitude of any one stressful event, but by virtue of both the individual's inherent high reactivity and the chronicity of the stress. Inadequate interpersonal skills and social support networks (the invalidating environment) preclude adequate problem solving. Repetitive stressful events, coupled with an inability to fully recover from any one stressful event, result in dysfunctional or other "emergency" behaviors. Suicidal behavior, then, can be conceptualized as a maladaptive response to a state of chronic, unrelenting, and overwhelming crisis.

Balancing the tendency to be in perpetual crisis is the corresponding tendency to inhibit the experience and expression of extremely painful emotional reactions. The inhibited

grieving syndrome refers to the pattern of repetitive, significant trauma and loss, together with an inability to experience and personally integrate the negative affect associated with these events. Often there is a history of one or more major loss patterns (incest, physical or other sexual abuse, death of a parent or sibling, parental neglect, etc.) at an early age. Borderline individuals seem unable to tolerate their extreme emotional responses to loss and so, rather than work towards the resolution of emotional experiences, they inhibit any emotional response, experiencing instead numbness, emptiness, and at times derealization and depersonalization.

The borderline individual often vacillates between intense overreaction (unrelenting crises) and just as intense underreaction (inhibited grieving). Each state can be viewed as a failure to maintain the extremity of the other pole. The task of the therapist is, first, to help these clients understand their reaction patterns and, second, to offer realistic hope that they can survive the process of grieving. Such realistic hope requires that the therapist teach coping skills needed to successfully accept and reorganize one's current life —that is, pattern recognition, behavioral analysis, and solution analysis, in an environment that validates the client's emotional experience and difficulty.

Dialectical Behavior Therapy

Dialectical Behavior Therapy (DBT) is defined by its philosophical underpinnings, described previously, its treatment targets, and the treatment strategies guiding the conduct of the therapist. DBT involves both group and individual treatment. Treatment targets in individual DBT are arranged hierarchically as follows: (a) suicidal behaviors, (b) behaviors interfering with the conduct of therapy, (c) avoidance and escape behaviors, (d) behavioral skill acquisition (emotion regulation, interpersonal effectiveness, distress tolerance, self-management), and (e) other goals suggested by the individual. Thus, behaviors that could potentially impede the course of therapy have priority before more advanced tasks can be given sufficient attention. Furthermore, attention is shifted to a target earlier on the list when problems in that area surface. Therapy, then, is somewhat circular in that target focal points revolve over time. DBT groups are used primarily for behavior skill acquisition such as emotion regulation skills, interpersonal skills in conflict situations, lifestyles interventions, and distress tolerance and delay of gratification skills. Integration of these skills into daily life is a task of individual therapy.

DBT involves eight basic treatment strategy sets. Four strategies common to other behavior therapies are *problem solving strategies,* an active attempt to "reframe" suicidal and other dysfunctional behaviors as part of the client's learned problem-solving repertoire, and emphasis on active problem solving; *capability enhancement strategies,* active teaching of the skills necessary to cope with a sometimes invalidating environment; *contingency strategies,* the use of interpersonal reinforcement to shape adaptive behaviors and extinguish those that are maladaptive; and *irreverent communication strategies,* matter-of-fact attitudes about current and previous parasuicidal and other dysfunctional behaviors. Also central to DBT are *dialectical strategies,* which utilize both dialectical thinking (paradox, metaphor, ambiguity, developmental analysis) as well as the dialectical tensions within the therapeutic setting to promote change; *consultant strategies,* which teach clients how to interact with others (specifically mental health professionals) and prescribe teaching others how to interact with the client; *validation strategies,* which require the therapist to search for the inherent validity and wisdom of the client's response patterns, even when these response patterns appear maladaptive; and finally *relationship strategies,* which utilize compassion, modeling, and generalization techniques to enhance the client-therapist alliance and facilitate interpersonal change and generalization to other relationships. These strategies are described further in Linehan (1984) and Shearin and Linehan (in press).

DBT as a Feminist Therapy

The reader atuned to feminist concerns may have noticed similarities between the philosophy and treatment strategies of DBT and those of feminist therapy. The major points of convergence are listed in Table 1. The most striking similarity between feminist therapy and DBT is in the underlying philosophies upon which the therapies are based. Feminist therapy attempts to integrate "the subjective and the objective, the rational and the intuitive, the mystical and the scientific, the abstract and the concrete aspects of the universe, and considers them harmonious parts of a whole, rather than opposites of one another" (Mander, 1977). Similar to dialectics,

Table 1
Comparison of DBT with Traditional Feminist Therapy

	DBT	Feminist Therapy
Philosophical Underpinnings	Dialectics: emphasis on interconnectedness and wholeness; all things are inherently heterogeneous, comprised of opposing forces which synthesize to produce change	Integration: the subjective and the objective, the rational and the intuitive, the mystical and the scientific, and the abstract and the concrete are considered harmonious parts of a whole
Goals of Therapy	1. reduction of suicidal behaviors	1. recognition of the harmful effects of a sexist society
	2. reduction of behaviors interfering with therapy	2. empowerment—empowerment of personal strengths and capabilities already acquired
	3. reduction of avoidance & escape behaviors	3. behavioral skill acquisition
	4. behavioral skill acquisition	
	5. other goals suggested by client	
Strategies	1. problem solving*	1. problem solving
	2. capability enhancement*	2. use of contradictions in client's experiences to produce change
	3. contingency* tion*	3. validation
	4. irreverent communication*	4. relationship
	5. dialectical	
	6. consultant	
	7. validation	
	8. relationship	

* Traditional behavior therapy strategies

wholeness is emphasized and opposites are synthesized (Miller, 1983). Integration is a goal, and conflicts are necessary (or at least useful) for change to occur (Adams & Durham, 1977; Mander, 1977; Miller, 1983). Perhaps the invalidating environment that both women and borderline individuals are known to experience necessitates this pespective. Similarly, women in our society often find themselves in double-binds (Hariot, 1983). They are expected to behave and feel in a variety of ways that are often contradictory.

Feminist therapy typically utilizes a variety of strategies to facilitate synthesis and change that are similar to DBT. First, the therapist constantly *validates* the client's feelings and behaviors, and similar to DBT, views maladaptive behavior as a natural response to an unpredictable environment (Gilbert, 1980). Second, *relationship* strategies stress an egalitarian alliance between the therapist and client (Butler, 1985; Gilbert, 1980). As in DBT, the therapeutic relationship is treated as representative of other interpersonal relationships the client may have. Problem solving can be facilitated through modeling and other behavioral techniques within the therapeutic setting. Third, the therapist helps the client recognize the inherent contradictions in the prescribed social roles for women (Butler, 1985; Miller, 1983). Although the word *dialectical* has not typically been associated with this strategy, it is perhaps appropriate. For example, *wholeness* is viewed as achievable, only by "recognizing the conflict-producing conditions within which [women] have lived so far" (Miller, 1983). The goal of many women is not to act "as men," but to change according to their own ideals, thus synthesizing the contradictions to which they have been exposed. A fourth strategy of feminist therapy, *problem solving,* is shared not only by DBT, but by other behavior therapies as well. The therapist teaches women how to accomplish goals through their own ideals, by utilizing a variety of behavioral techniques (e.g., assertiveness training, self-esteem enhancement, career counseling, etc.) (Harmon, 1977; Jakubowski, 1977; Stere, 1985).

The goals of feminist therapy (Smith & Siegel, 1985) are perhaps the most discrepant aspect of the comparison with DBT, although they are by no means incompatible. One goal of feminist therapy is to help the client recognize the harmful effects of the sexist society in which we live. A second is to introduce the woman to her own strengths. "Empowerment" has often been used in this sense, as a means of helping women gain awareness of the power they already have. Finally, (although admittedly there exist potentially many other goals of feminist therapy), an important task of the feminist therapy is to teach new, more effective behaviors in the woman's personal and work environments. This last goal is quite similar to the goal of behavioral skill acquisition in DBT. In addition, the "other goals" targeted by DBT could potentially include the first two goals of feminist therapy. By virtue of its development for severely dysfunctional clients, however, DBT targets the maladaptive patterns that could disrupt the course of therapy before these "other goals" can be reached. This is a main distinction between traditional feminist therapies and DBT. Additional distinctions can be noted between the two therapies. First, whereas DBT focuses on the interaction between biological factors and the environment, feminist therapy primarily focuses on the influence of the environment. Also, the environment is viewed in the feminist perspective as sexist, and in the DBT view as invalidating (of course, sexism contributes to invalidation and for some women may be the major invalidating component of their lives).

In summary, although behavior therapy has not traditionally been aligned with feminist theory and therapy, the addition of a dialectical component leads to a convergence of values and strategies between the two approaches. Behaviorists have always recognized the influence of destructive environments on behavior. DBT specifies the invalidating environment as central in the etiology of borderline personality disorder. This emphasis on invalidating environments is quite similar to the feminist attention to sexist environments that make incompatible, contradictory demands on women and invalidate their experiences in the world. From our perspective, behavior therapy, as a radical attempt to induce change, may have much to gain by incorporating a dialectical perspective. "Just as many radical social movements are grounded in dialectical thinking, so should radical approaches to counseling include more investigation into dialectical models of personal change" (Adams & Durham, 1977).

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