

Just What Is “Dialectical” About Dialectical Behavior Therapy?

To the Editor: Regarding the recent study published in the *Journal* by Goodman et al,¹ one possible explanation for the failure of dialectical behavior therapy (DBT) to demonstrate significant improvement is criterion deficiency resulting from a misapplication of the term *dialectic*. Using fancy words like *dialectic* is inherently suspicious, particularly in unexpected, anomalous contexts—such as psychotherapy. When asked to explain what it means, most DBT clinicians will make odd gestures with their hands and say something about “validating the client” while simultaneously “pushing for change.” As a result of which, presumably, they get better. This certainly is the emphasis of Dr Marsha Linehan’s most sustained reflections on the topic.²

The problem is that this has nothing to do with the concept of dialectics, which envisions a state transition from thesis to antithesis to synthesis. Thesis and antithesis are contradictory; they result in a new, inconsistent state of affairs—synthesis—which then develops its own internal contradictions.³ The antithesis renounces the thesis, and then the synthesis renounces both. They are mutually incomprehensible. In logical notation, this looks like:

$$t \rightarrow (a \wedge \neg t) \rightarrow s \wedge \neg (t \vee a)$$

Whereas Linehan’s concept of dialectics looks like:

$$t \wedge a \wedge s$$

Contemporary understanding of dialectics initially is based on the work of the German philosopher G. W. F. Hegel.⁴ Hegel believed that the ultimate expression of history was something he called “spirit,” which is a form of something else he called “absolute mind,” both of which are terms that have no discernible referents (and appear to have been adopted uncritically by DBT). Dialectics was then picked up by the social theorist Karl Marx, who hypothesized that late-stage industrial capitalism, when juxtaposed against worker dehumanization and alienation, would result in utopian communism.⁵ It since has proliferated to numerous other contexts, many involving psychiatry; for example, the migration from psychoanalysis to behaviorism to cognitive therapy is dialectical.

This is not what happens with DBT. The antithesis of “validation” is “rejection,” not “change.” Validation and change aren’t true opposites, because clients aren’t required to abandon the former in order to experience the latter. They don’t have to repudiate their past, nor should they be required to do so. DBT correctly characterizes this process as “both/and,” not “either/or.”⁶

Their synthesis in turn is not a valid recombination. Clients often get better (or do not) for reasons that have nothing to do with acceptance or change. They don’t move forward toward an outcome. Rather, the process of therapy is evolutionary—a “random

walk”⁷ incorporating (nonexclusively) flexible thinking, adaptive behavior, and emotional awareness. “Change” is a description of what happens, not a maneuver within a collection of procedures. Its mechanism of action is diachronic (ateleological movement through time) or a set comprising a nondeterministic longitudinal series of synchronic moments (discrete points in time). As Wittgenstein might have said, there is no such thing as progress in psychology. Despite this, DBT still prescribes a rigorous initiation into what it incorrectly calls “dialectical thinking.” DBT is a good thing; however, it is not dialectical.

This confusion permeates DBT as applied, and is incomprehensible to clients, especially concrete ones (like many in the Veterans Administration). Holding two opposing thoughts in your mind at the same time is far more effortful than holding two complementary ones. Clinicians should divest themselves of the concept of “dialectic” and focus instead on emotional regulation, which is DBT’s most important theoretical contribution. It also is what most clearly distinguishes it from cognitive behavioral therapy; DBT is CBT’s counterpart, and it really should be called “emotional behavioral therapy” (EBT), abandoning any tenuous and misleading ties to “dialectics.” I suspect that DBT would have resulted in significantly more improved outcomes in this study, had emotional regulation been the focus of therapy.

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Drs Goodman and Hazlett Reply

To the Editor: Dr David Kronemyer’s letter to the editor expounds on the misapplication of dialectic principles in the dialectical behavior therapy (DBT) treatment approach and suggests that instead, clinicians should focus on “emotional regulation...DBT’s most important theoretical contribution.” We agree with this point.

Our research group has spent the last 20 years examining the biological underpinnings of borderline personality disorder and more recently focused on the role of affective instability and emotion dysregulation in the etiology of the disorder. We are particularly interested in DBT, an evidence-based treatment, because it targets affective instability by teaching emotion-regulation skills. Exciting advances in neuroimaging have provided clinical investigators the ability to visualize brain activity and circuitry, which we leveraged to study the role of the amygdala and its changes with 1 year of DBT treatment in patients with borderline personality disorder.¹

Our functional magnetic resonance imaging study indicated that unmedicated borderline personality disorder patients receiving standard 1-year DBT therapy¹ showed a reduction in overall amygdala activation following 12 months of DBT treatment. In addition, among the borderline personality disorder group, improvement in emotion regulation and strategy as measured by the Difficulties in Emotion Regulation Scale² was associated with decreased amygdala activity to repeated unpleasant pictures. These neurobiological findings highlight the importance of emotion regulation skill acquisition as a critical component to DBT’s treatment effect.

Our recent randomized controlled trial³ examining the effect of a 6-month DBT intervention on suicide-related clinical outcomes in a sample of veterans at high risk for suicide, irrespective of diagnosis, showed that both DBT and treatment as usual result in statistically significant improvements in suicidal ideation, depression, and anxiety that did not differ between treatment

arms. Future research is needed to focus on the negative valence system and its underlying neural circuitry (eg, amygdala and related regions), as this circuitry is a promising treatment target for suicidal behavior.⁴ However, emotion dysregulation is not the only pathway for the expression of suicidal symptomatology. Other treatment approaches will be necessary to augment treatment response in these high-risk individuals.

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