

## TOPIC #1: “DIALECTICS” WITH AN ADOLESCENT POPULATION

One of the most difficult things to explain about Dialectical Behavioral Therapy (DBT) to families, funders, and clients is the concept of “dialectics”. It is easy for people to understand the more concrete and simplistic descriptions we often use to describe behavior therapy (i.e. reward positive behavior, punish negative behavior). Similarly, explaining cognitive therapy can be as easy as “if you change the way you think, you’ll change the way you behave”. Ironically, I encounter the same dilemma when I try to explain Borderline Personality Disorder (BPD). Most people, adolescents included, report that they have heard about BPD. However, when asked to expand on their knowledge of BPD they often go on to describe it as bipolar disorder, admit they have no idea how to describe it, or describe it in vague terms such as anxiety or depression.

As mentioned in last month’s column, DBT is basically, a combination of Eastern and Western philosophy, and Cognitive-Behavioral principles. Dialectical philosophy is ancient, emerging from many of the early philosophers like Socrates, Plato, and Hegel. The integration of this age-old term in modern psychology, and its application to youth who often struggle with abstract concepts and ideas can be challenging to say the least. This article concentrates on the basic definitions and practical use of these terms and interventions with an adolescent population.

### The Meaning of Dialectics

Fichtean/Hegelian Dialectics is based on these basic concepts (no author, 2010):

1. **Everything is transient and finite**: Change is inevitable and constant
2. **Everything is made out of opposing forces or contradictions**: There are no absolutes
3. **Gradual changes lead to turning points, where one force overcomes the other**: The tension that is created by opposing forces eventually gives way to one behavior, idea, or emotion becoming primary.
4. **Change moves in spirals not circles**: Development is not circular, but builds on itself, so that change happens in stages, with the previous stage as the foundation for the next.

With adolescents and adults, I tend to introduce dialectics by defining its meaning to be that two opposites can both be true. For example, someone may really want to do well in school, but may feel so frustrated and hopeless that he/she doesn’t try. When we can experience our life through this understanding, it helps us avoid extreme emotions, like rage, depression, or panic, helps us act with less extreme behaviors such as substance abuse, risky sex, or cutting, and helps reduce extreme thoughts such as hating others, paranoia about how others perceive us, or suicidal thinking or plans.

The above descriptions of dialectics help us to start understanding the meaning of the term, but how do we actually apply dialectics in our clinical practice?

## Dialectical Persuasion

The term “Dialectic” comes from the word “dialogue”, and denotes a conversation between people who wish to persuade each other to change their differing ideas (no author, 2010). Much of what we do as helping professionals is to persuade our clients to change. We often have to persuade clients to enter treatment in the first place, then we spend much of our time hoping for and helping them achieve change. Some of us use direct approaches to do so such as confrontation, or examining distorted beliefs, and some of us are more passive in our approach, waiting for the client to find his or her own motivation to change. Regardless of our preferred approach, A dialectical approach can help clients view perspectives that are different from their own, and in turn may facilitate change.

Cognitive-behavioral psychologists are trained to use the Socratic method to help clients expand their perspectives. Relentless evaluation of a distorted belief leads to the identification of core beliefs that influence the individual’s behavior, and brings to light contradictions between thoughts, behaviors, and realities. The Socratic method can be particularly powerful with adolescents, as their decision-making capabilities are much less advanced than adults, and therefore their arguments for their beliefs or behaviors are commonly flawed and inconsistent. According to Ayer & O’Grady (1992), and McTaggart (1964), this method is a means of helping clients adopt a dialectical worldview:

In classical philosophy, dialectic is a form of reasoning based on the exchange of arguments and counter-arguments, advocating *propositions* (theses) and *counter-propositions* (antitheses). The outcome of such an exchange might be the refutation of one of the relevant points of view, or a synthesis or combination of the opposing assertions, or at least a qualitative transformation in the direction of the dialogue (cited in no author, 2010).

Many of the interventions utilized in DBT to help clients adopt a dialectic worldview will be discussed in upcoming topics within this series. However many clinicians make the mistake of using random interventions without conceptualizing the client’s needs first, therefore it is important to consider which interventions are the most likely to assist the client in thinking more dialectically. To do so, it is important to understand the principals of dialectics in its practical application. Linehan (1993) terms these three core principals: 1.) the principal of continuous change; 2.) the principal of polarity; and 3.) the principal of inter-relatedness and wholeness.

### *The Principal of Continuous Change*

As mentioned above, it is the tension between the thesis and antithesis that creates change, or synthesis. For example, dichotomous thinking (thesis) is developmentally appropriate in adolescence, especially early adolescence. Yet, even if this thinking is not diagnostic, it can give rise to impulsive behaviors, relational conflict, and poor decision making (antitheses). In addition, this black and white thinking creates

frustration for clinicians, who struggle to help clients find the shades of gray in life. Framing things dialectically allows us to identify these contradictions (theses and antitheses) exposing truths and untruths in both, in order to construct a more balanced world view (synthesis).

### *The Principal of Polarity*

Creating synthesis requires us to understand the principal of polarity. All symptoms, elements or dynamics of a person or situation have a polar opposite. For example, many individuals with BPD harbor a deep sense of shame about who they are. While shame is a very difficult emotion to overcome, Linehan (1993) suggests that all individuals have the capacity to reduce these feelings through self-validation. This principal helps empower youth to complete therapeutic work, and motivates them to work in therapy. In addition, assessing people's strengths and needs, rather than just their needs, allows us to draw on the positive traits, skills, and attributes that they have in order to overcome their limitations.

### *The principal of inter-relatedness and wholeness*

Being part of a larger system or purpose, and understanding that we are all connected assists individuals with BPD to overcome feelings of emptiness, rage, and loneliness. Another developmentally appropriate trait in adolescence is self-centeredness, making it difficult for youth to understand how their behaviors impact others, and to value their roles within their communities. As Linehan (1993) points out, this principal is in line with feminist psychology, which emphasizes the role of society on women's thoughts, feelings, and behaviors. Similarly, this principal also compliments the principals found in addiction recovery models, in that taking responsibility for ourselves includes increased investment in our communities, as well as surrender to a higher power greater than ourselves.

### ***Dialectical dilemmas***

In addition to outlining the principals of clinical dialectics, there are three dialectical dilemmas Linehan (1993) suggests are common in individuals with BPD. Although a detailed description of these common dilemmas is beyond the scope of this topic, a brief explanation of each is provided in the table below. It is important to remember that constant client assessment, consultation, and self-assessment are inherent in the DBT model, and that these dialectics are common, but not necessarily present in all individuals. In addition, the clinician's open self-evaluation and consultation within a team are necessary to prevent contributing to these dialectical dilemmas. The idea of self-evaluation for clinicians will be discussed in upcoming topics within this series.

Dialectical Dimensions	Dialectical Dilemmas	Patient Response	Clinician Response
<p><b>Unrelenting Crisis</b></p> <p><b>VS</b></p> <p><b>Inhibited Grieving</b></p>	<p><u>Unrelenting Crisis-</u> One of the most challenging aspects of BPD is the chronic crises, and the high risk nature of these clients. These crises increase the risk of burnout in clinicians, and interfere with treatment plan implementation.</p> <p><u>Inhibited Grieving-</u> There is a high degree of comorbidity among PTSD and BPD (Favazza, 1996). Repetitive, significant trauma or loss and a tendency to avoid the trauma or loss is common.</p>	<p>Vascilation between crisis and avoidance makes it difficult for clients to maintain a stable affect and resolve traumas, and also to avoid being re-traumatized. Clients are in a perpetual state of feeling unsafe, and therefore have many treatment implications as a result.</p>	<p>Balance validation and support, with encouragement and therapeutic work. Setting healthy limits and maintaining clear boundaries assists the client to have clear expectations and avoid re-traumatization in therapy. Crisis management and learned coping skills helps the client avoid and manage crises outside of session.</p>
<p><b>Emotional Vulnerability</b></p> <p><b>VS</b></p> <p><b>Self-Invalidation</b></p>	<p><u>Emotional Vulnerability-</u> Clients experience a sensitivity to emotion, high arousal, slow return to baseline, and inability to manage emotions.</p> <p><u>Self-Invalidation-</u> There is a tendency to think and/or speak negatively about oneself, feel shameful, disallow one's feelings.</p>	<p>Client blames self or others for his/her pain. Needs patience, acceptance, and self-compassion. Emotion regulation and self soothing skills (to be discussed in upcoming topics) are designed to help shape behavior.</p>	<p>Client's tendency to blame others makes clinicians at risk for invalidating clients. We must be able to tolerate their tendency to lash out, and strive to balance validating experiences and feelings, and promoting change.</p>
<p><b>Active Passivity</b></p> <p><b>VS</b></p> <p><b>Apparent Competency</b></p>	<p><u>Active Passivity-</u> A tendency to approach life passively and helplessly, while demanding external solutions to one's problems.</p> <p><u>Apparent Competence-</u> A tendency to act competently in some situations, and helplessly in others.</p>	<p>The client's inability to synthesize the need for support and feelings of helplessness, with periods of competence and success creates guilt and hopelessness, as well as self hate.</p>	<p>Providing sympathy instead of empathy encourages helplessness. However, being unresponsive to client's needs during low levels of functioning is invalidating and dangerous.</p>

The dialectical dimensions in the table above can be assessed throughout treatment and managed by using the clinician responses described. However, one can imagine from the complexity of these dilemmas the tremendous care it takes to not only assist clients in remaining balanced in their responses to these dilemmas, but to remain balanced in our own responses to these dilemmas.

***Ongoing topics with regard to DBT***

Dialectics and the dialectical dilemmas we and our clients face help us to understand the driving force of the DBT model. Next month's topic will explore ways to use dialectics to orient clients and families, as well as the assumptions behind DBT, and some of the challenges facing implementation of a DBT model.

References

Favazza, A. R. (1996). *Bodies under siege: self-mutilation and body modification in culture and psychiatry, 2nd Edition*. Baltimore, MD: Johns Hopkins University Press.

Linehan, M. M. (1993). *Cognitive therapy for Borderline Personality Disorder*. New York: Guilford Press.

No author. Downloaded from <http://www.reference.com/browse/dialectic's> on August 15, 2010.