
CHAPTER 3

The Acceptance Paradigm

ACCEPTANCE AND MINDFULNESS IN THE PRACTICE OF DBT

To recapitulate the DBT treatment development story, Linehan started with the change paradigm, applying problem-solving strategies from CBT to the treatment of suicidal behaviors. She added acceptance-based strategies to address the patient's suffering and to facilitate the use of CBT. To this mixture she added strategies from a dialectical perspective to address the problems of rigidity, polarization, and conflict that are typical of these therapies. But we begin our formal discussion of the three paradigms with acceptance for several reasons. First, it is the oldest of the three, the beginnings of it being traceable back to the life of the Buddha more than 2,500 years ago. It is a deep root of the "Tree of DBT" (see Chapter 6). Second, in most cases the use of acceptance-oriented interventions is a prerequisite for the effective use of cognitive-behavioral and dialectical strategies. "Getting into hell with the patient," as discussed in Chapter 1, is essential in helping the patient find a way out of hell, and it requires careful listening and validation, essentially acceptance and heightened awareness. Third, ideally we enter into each therapy session, skills training group, telephone coaching call, and consultation team meeting with an open mind and a compassionate, accepting heart. I don't have empirical data to prove it, but my conviction, born out of clinical experience, is that I am more effective at helping my patients change when I start from an accepting—awake, alert, nonjudgmental, and fully present—stance. When I am truly and fully present at the beginning of a session, my patients notice. I can tell that they can tell. And it injects the session with a sense of relevance and immediacy. Finally, we begin here

with the explication of the acceptance paradigm because in the teaching of DBT's skills modules, the acceptance-based mindfulness skills are central to the teaching of every module, and are thus named the *core mindfulness skills*. Practicing mindfulness skills is integral to the learning and practice of the others.

The acceptance paradigm in DBT is based, above all, on the principles and practices of mindfulness. Mindfulness is an innate capacity of the human mind, the capacity to see the unfolding of reality clearly, directly, in the here and now, moment by moment, without "delusion." Although introduced through mindfulness meditation by the Buddha about 2,500 years ago, the basic concepts and practices can be found in every spiritual tradition around the world, and in secular traditions as well. Mindfulness happens unintentionally when we "wake up" in the present moment. For instance, we suddenly become mindful, fully awake and alert to present reality, when we experience a threat to our lives or our well-being. This same state can be cultivated intentionally by meditative practices to bring present-moment awareness into all aspects of our lives, thereby enhancing our well-being. In fact, the practice of mindfulness meditation throughout the centuries has given rise to certain insights that form the core of the principles of DBT's acceptance paradigm. Whereas the totality of practices and insights from meditation provide nourishment for the DBT therapist, five overarching principles are particularly relevant:

1. *Present-moment awareness.*
2. *Nonattachment.*
3. *Interbeing.*
4. *Impermanence.*
5. *"The world is perfect as it is."*

In concert, these principles promote awareness, acceptance, and compassion. They lay the groundwork for validation strategies and DBT's reciprocal communication style, and constitute one of the primary means with which therapists regulate themselves during therapy.

PRESENT-MOMENT AWARENESS

Perhaps the concept and practice at the core of the acceptance paradigm—the prerequisite for the other acceptance principles—is this one: The present moment is the only moment. When our attention is fixed on the past, it is fixed on a memory, a story, a fiction of sorts. When our attention is drawn to the future, it is drawn to a fantasy. In a mindfulness retreat

with Thich Nhat Hanh, he was asked how one could ever plan for the future if one's attention never left the present moment. Thich Nhat Hanh answered that the best planning for the future happens when one brings the future into the present moment, not when one abandons the present moment to enter into the future. The present moment is the host; the future is the invited guest. He went on to say that the same goes for considering the past. One can invite the memories of the past into the present moment without losing one's grounding in present-moment reality. Reality is here, it is now, and it is taking place whether we are aware of it or not. We just need to wake up and notice, and when we do, that present-moment awareness transports and transforms us, invisibly, instantly, back into reality. Thich Nhat Hanh (1975) called this state the "miracle of mindfulness."

When we inhabit the present moment, with awareness of the sensations, perceptions, thoughts, and events that reside therein, we are rooted in reality while we do whatever else we do. Whether we are hosting the past or the future, or we are engaging our DBT patients in problem solving, we try to stay grounded in the present moment. The individual who is "hijacked" by memories of a traumatic past, or who is racked with worry about the as-yet-unreal future, is not experiencing the present moment, is thereby grounded in the unrealities of the past or future, and is invisibly handicapped. Complicated grieving, posttraumatic stress, panic, intense anxiety, and worry are associated with the kind of past or future hyperawareness that eclipses the present moment. When patients are overtaken by traumatic reenactments, in some cases to the extent of dissociating from the present, "grounding" techniques are specifically aimed at helping them reclaim present-moment awareness. When patients are swept away with anxiety set off by envisioning catastrophic future outcomes, skillful therapists help reconnect them to reality by asking them to observe and describe associated sensations taking place in the here and now. When depressed patients involuntarily withdraw into cocoons of depressive ideation about the past, the future, and the world, DBT therapists help them to schedule and carry out activities that rivet their attention and awareness to the present moment. The influence of present-moment awareness—and the loss of present-moment awareness—is ubiquitous, constant, and consequential.

As one learns in DBT's Core Mindfulness Skills module, the practice of observing and describing the realities of the present moment and participating fully in it provides pathways to finding wisdom within oneself. The practice of observing and describing sensations, emotions, urges, distress, behavioral responses, and relationship events as they occur in that moment is a prerequisite for effectively participating in the three other

skills modules, in which the patient is attempting to change emotional responses, tolerate distress, and change relationship patterns.

And for therapists (essentially, every one of us), who are time and time again derailed by the emotional reactions, problematic cognitions, and misperceptions of patients as they are drawn into reactions to the past, fears of the future, and sparsely based interpretations of present reality, the practice of reclaiming the present moment becomes central to clear seeing, to acceptance of reality, and to therapist self-regulation. At times, when therapists are not “residing in the present moment” and then become aware of that fact, they can reenter the present by bringing attention to their body, noticing the contact of their body upon the chair or their feet on the floor, and experiencing that their center of gravity shifts downward into the abdomen. That is, present-moment awareness is at the core of the skills at the center of each therapist’s self-care, and completely necessary to the very important process in DBT of *radically accepting reality*.

NONATTACHMENT

From a Buddhist perspective, derived from more than 2,000 years of mindfulness meditation, attachment is the root cause of human suffering, and letting go of attachment is a core practice in reducing that suffering. *Attachment*, in this therapeutic context, does not refer to the attachment between beings. Attachment between patient and therapist is a crucial ingredient in DBT treatment. It refers instead to an attachment to beliefs, perceptions, possessions, preferences, and states of mind. If a person has arthritis of the hip, as I do, he experiences pain. If, in addition to that physical pain, he is attached to the belief that he should not have arthritis or that it is not fair that he has arthritis, then he is adding suffering to his pain. If a person is attached to remaining youthful, then the inevitable painful realities that accompany aging are aggravated further by the belief that it should not be so. For the person who is attached to health as if it were the only acceptable or fair state, that attachment will add suffering to the natural discomfort of illness. Those for whom the painful loss of a relationship, a person, a pet, or a job is simply unacceptable and never “should” have happened, will suffer from that nonacceptance in addition to the inevitable grieving. Having acquired the insight that life is inevitably filled with pain, and that resisting or protesting those painful realities causes additional suffering (known respectively as the First and Second Noble Truths of Buddhism), the Buddha then taught that the alleviation of suffering comes from acknowledging and accepting

reality as it truly is, while letting go of attachment to beliefs, perceptions, possessions, and states of mind (Third Noble Truth of Buddhism). From these insights arises the familiar (though unattributed) saying, “Pain is inevitable; suffering is optional.”

Applications of these discoveries abound in DBT. I once was asked to consult on an individual who was diagnosed with both borderline and antisocial personality disorders to provide recommendations and to consider whether he was an appropriate candidate for DBT. He was in jail (for stealing several large electronic items from a “big-box” store) and was intolerant of how he was being treated. He promptly became emotionally dysregulated and lashed out at several other inmates and a prison guard. When I saw him, he was in an isolation cell and I was not allowed to be in the same room as he. I interviewed him through a 1-by-10-inch horizontal slot in a solid door, about 3 feet off the ground. All we could see were each other’s eyes. Early in the interview I asked him if he had any hopeful or meaningful image of the future, something toward which he could work. His eyes were expressive, softer than I expected, and they moistened as he pleaded with me: “All I want is to get out of this cell. It just makes me worse. I can’t stand it! I can’t even think about anything. Do you think you could get me back to a regular cell?” I softened as I listened to him. I felt his suffering and I noticed the urge to advocate for him. Did he really have to be in isolation? I imagined how awful it would be to be in isolation.

Alongside my empathic response to his situation, which was stronger than I expected, I also knew that he had contributed to his current status in significant part due to his deeds and his choices. Somehow he had “earned” his place in solitary. I was aware of an urge to rescue him as well as an urge to mistrust him. I was silent as I let myself take in this already-complex reaction. I just sat there, noticing him, observing my responses. I was letting my mind settle, and toward that end I brought my attention entirely to my breathing—one breath in and one breath out—then waited for a “wise mind” response to arrive. It occurred to me that in addition to the reality of being in isolation, and the realities that led to that predicament, and the reality of his discomfort, there was, *in addition*, a great deal of urgency. He wanted out of there. That was foremost on his mind. He was intolerant of his in-the-moment reality.

I said to him, “I certainly get that it is horrible for you to be in solitary. I’m sure it would be for me.”

“Yeah, so get me out of here,” he said in a somewhat demanding way, as if I had the authority to do so and as if he had the authority to command me. By that time in the interview I felt no pressure to rescue him or to accuse him. It was as it was.

“I don’t really have the authority to get you out of here, and I don’t really know the story about why you are in solitary. But I wonder if you could just settle in to where you are right now, just let yourself be where you are, and talk to me. If you spend every waking second convinced that you have to get out of there right now, you might suffer even more. If you could accept that you are where you are, for now, truly accept it, maybe you would feel less agitated. Who knows, maybe you would even end up getting out sooner if you were to stop thinking you had to get out.” (This last comment, flowing easily from a mindful, accepting stance, is also an example of “entering the paradox,” one of the dialectical strategies in DBT.)

I’m pretty sure I saw a cloud of anger cross his eyes, and he looked down at the floor and said, “I suppose you think I should just suck it up?”

“No,” I said, “Actually that’s not what I mean. I mean that if you just stop thinking you have to get out right away, stop counting the minutes and seconds, maybe you will tolerate it better. And then time will pass, and you’ll be out.” I thought I saw a flicker of interest come into his eyes.

This patient was attached to an outcome over which he had very little control: immediate transfer out of isolation. His attachment to getting out immediately was causing him additional suffering and increased dysregulation in his emotions and actions, further perpetuating his stay in isolation. If he could accept the reality and instead find a way to just *be in that moment*, maybe he would get out faster.

When I first began speaking with him, I experienced an immediate attachment to rescuing him, getting him out. If I had stayed attached in that way, I too would have suffered more and would have been of little use to him. To help him I had to notice, and let go of, the urge to rescue him. Although this example arose from a unique situation, visiting a patient in prison, the process of getting attached to “shoulds” or wishes happens in every session. Every session presents us with the opportunity to get hooked (attached), to suffer, to notice that we are hooked—that is, to wake up—and to let go of the attachment so that we can find our balance again.

Let’s review the steps in this example for the sake of generalizing this process to other types of traps and attachments in therapy. First, I became attached. I “felt his pain,” I empathized with his urgent desire to get out of isolation. His attachment became my attachment before I even thought about it. Second, and this is the key to the whole process, *I recognized that I was attached*. This need to rescue is not unusual in doing therapy with individuals who exhibit high levels of emotional dysregulation. The feeling grabs hold of us that we have to *do* something. We get attached

to doing something when, in fact, nothing needs to be done. If we recognize our sense of urgency, only then are we positioned to reestablish our freedom and balance, and only then do we stand a chance of helping the patient. Third, actually letting go of the attachment, even when we see that we are attached, is not necessarily so easy. In this case I was helped by the practice of stepping back, going within myself, and observing one entire in-breath and out-breath, with full attention to the breath. We often need a vehicle like this when we are midstream in trying to get unhooked from an attachment. By analogy, if we drive a car with a manual transmission, and we want to shift from one gear to another, we need to push the clutch pedal all the way to the floor in order to shift. Engaging the clutch pedal allows us to disengage from our present gear, allowing us to then shift to the new gear. In therapy we routinely get trapped in one “gear” or another, and we need a “clutch pedal.” We may be attached to preventing our patients from engaging in suicide attempts or self-harming episodes, substance use, or dissociative episodes. Or we may be attached to ensuring that our patients show visible progress. Or we may be attached to not becoming a target of their anger. The more we get attached to those things over which we don’t have control, the more we get emotionally dysregulated, the more we suffer, and the less effective we become. It’s an interesting paradox of DBT: If we get too attached to the outcomes, day by day, in this outcome-oriented treatment, we might become more dysregulated and less effective at accomplishing the outcomes.

To return to the example of the patient who was in isolation: (1) I had quickly become attached, as he was, to getting him out of isolation; (2) I then recognized that I was attached; (3) I managed to shift gears, to “let go” of my attachment with the assistance of one conscious breath; now (4) I could see the patient’s dilemma, the suffering he was bringing on himself via his attachment, more clearly, more separately, and then I was in a position to help him cope with reality. Then the paradox occurred to me—that he might get out sooner if he stopped trying to get out—and I could communicate it to him. His puzzlement and ambivalence about my suggestion threw him off balance and opened the door to a fresh start. A quick and dirty protocol for this process might be captured as follows:

1. *Get attached* (immediate, involuntarily, automatic).
2. “*Wake up*” to the recognition of being attached.
3. “*Let go*” of the attachment, possibly with the assistance of a mindfulness vehicle.
4. *See the patient’s reality as it is.*
5. *Intervene* strategically to help the patient with his or her attachment and suffering.

Sometimes the step of letting go, #3, is much more difficult than I have conveyed. Therapists might recognize that they are in a “trap,” but cannot see their way out. For instance, I was once conducting a DBT family session in which an older adolescent girl with emotional dysregulation and a developmental disability was sitting between her two parents. The parents alternated in “trying to talk some sense into her” about her recent begging on the streets. She grew more and more silent and surly, and I tried everything I could think of to create movement and change in an increasingly deadly dialogue. I was getting nowhere. I was attached to changing this evolving family dynamic, which seemed to be beyond my control, and my sense of helplessness and hopelessness grew as I continued. I couldn’t find a way out. I knew enough to know that I was stuck but not enough to know how to move things forward. Whereas in the prior example, I was able to let go of my attachment with one full conscious breath, that proved insufficient in this context. I needed a more substantial vehicle to clear my mind. Having never done so before, I announced a 5-minute break, stating that we were getting nowhere and would need a fresh start. I suggested that each of us take 5 minutes to do whatever it would take to clear our thinking, and then reconvene.

My office was in a mill building next to a large stream. I quickly went down to the stream, and emptying my mind of my feelings of entrapment in the family session, I just watched twigs and leaves float downstream, making their way past logs and big rocks. I entered that moment and let myself notice the details. At least for those few minutes I was able to get out of the stifling loop in which I found myself. I returned to the session, still not knowing what I would do next, but allowing for the suspended transitional state and hoping that my “wise mind” would generate a different intervention. When I sat down, I said to the adolescent that I wanted her to take over the leadership of the session. She looked puzzled and anxious. I assured her that she couldn’t do any worse than I was doing. I asked her to trade seats with me, and I took the seat between her parents. She sat in my chair, placed a clipboard and a piece of paper on her lap, and announced, rather definitively, “Things are not going very well in this session; we have to change direction.” She was surprisingly assertive, a radical shift from her usual passive posture. We all waited. She continued: “I think we need to talk about how parents talk to a daughter that embarrasses them.” We moved into a productive discussion about how much the parents were embarrassed by their daughter’s behaviors on the streets of their small town.

Honestly, upon review of my decision to make the patient into the “therapist” and move myself into her place, it is a mystery how that

idea came to me. Maybe it was a “wise mind” therapeutic decision that evolved from “emptying out” my anxious mind and just observing the flowing of a stream. Maybe the value of the intervention resulted simply from “breaking set” when things had been so stuck. Perhaps positioning myself as an “observer” between the two parents was key, structurally changing the balance of power in the session so that the patient could “borrow” the power of the therapist’s position. I’m not sure. But in my experience the decided shift from “doing” to simply “being” gives rise to all sorts of surprising and unpredictable openings.

INTERBEING

Ordinarily, we consider boundaries to be common and necessary (“Good fences make good neighbors”); we assume that each of us has a “self” that is unique and distinct from others’ selves; and that beings, although connected to each other, are mainly separate and unique. But from another perspective—one that emerged from mindfulness meditation practices for millennia that requires a relaxation of conventional perception and thought—reality has no boundaries; *Interbeing* is the rule, and the concept of self is a delusion. We take certain “boundaries” for granted in our lives: the boundaries between life and death; between oneself and others; between the past, present, and future. The closer and more carefully we examine these assumed boundaries, however, the more blurred they become. When we deeply consider the boundary around the beginning of life, it is nearly impossible, and at times controversial, to define that moment. When we examine the boundary between life and death, we are impressed with the uncertainty about where life ends and where death begins.

When my father was dying, I sat alone with him, holding his hand, as his breathing became slower and slower, and I knew he was in the process of dying. I felt absolutely present and with him in a profoundly interconnected way. I recognized that he was in me, and that I was in him. His breaths began to be spaced 10, 20, 30 seconds apart. Then they seemed to totally stop . . . or did they? In my experience, he was still alive. When his breath did not return for several minutes, but he looked roughly the same, I still thought of him as being alive, yet somewhere in the process he had died. He was no longer alive, yet in another sense he was as alive within me as he had ever been. Never before had the boundary between life and death struck me as so fragile, so undefined. He was now dead, and yet he was still alive. He was somewhere, I thought: in the room, in the wall, in the atmosphere, maybe still in his body, and definitely in me. It was, to say the least, a mystery.

And when we look just as carefully at the boundary between ourselves and other people, asking exactly where we leave off and they begin, and what part of them is us, and what part of us is them, again we lose the edge, the definition of the boundary. When I teach, I generally feel as if I am having my own thoughts, presenting my ideas with my speech and gestures. It is my “self” speaking, my unique self, and the members of the audience listening, “over there.” But when I have an idea, speak my idea, use a gesture, it sometimes dawns on me that all of the ideas, words, and gestures came from others. My grandfather, who was a dairy farmer for most of his adult life, traveled around to other farmers, giving lectures and leading workshops. His father had come from southwestern Sweden; in fact, I teach workshops in southwestern Sweden, perhaps to relatives of mine without my knowing it. My father was a soloist in our church choir when I was a boy, holding the attention of audiences. My oldest brother was a national champion as an orator in high school. My ideas come from the ideas of others. While teaching a workshop or seminar, I am influenced every second by my students in the ideas, words, intonations, and gestures that I choose. When you add it all up, literally nothing is uniquely “mine.” The concept of *mine* dissolves into the recognition of *interbeing*, of profound interdependency. For Buddhist teacher Thich Nhat Hanh, this leads to an understanding of the term *emptiness* in Buddhism: As he explains, “In fact, the flower is made entirely of non-flower elements; it has no independent, individual existence. It ‘inter-is’ with everything else in the universe” (1995, p. 11). Extending that concept to the self, “Charlie Swenson is made up entirely of non-Charlie Swenson ingredients.” *Interbeing* and *emptiness* go hand in hand.

Borrowing further from a metaphor of Thich Nhat Hanh, we can think of each one of us as a wave in the ocean, rolling toward the shore, from birth in the ocean to death on the shore. Each wave has its own shape, size, speed, and other features; has its unique story and form. On the other hand, every distinct wave is made up entirely of water molecules, the same as all other waves. In fact, a given wave is made up of water molecules that were part of a different wave moments before. The waves are historically unique and distinct, *and* they are profoundly interconnected and interdependent. We are waves, and we are water. Both are true, and we can shift our focus back and forth between the unique waves and the indivisible water. In fact, both “realities” are valid: the conventional, historical reality honoring uniqueness and separateness, and the deep truth of the interdependence of all elements all the time, as captured in the term *interbeing*.

It is but a short leap from these ideas to the idea of *non-self*. Without boundaries, without separateness, independence, or uniqueness, each of

us is but a temporary, evolving, interdependent rearrangement of matter and energy. Experiencing life from this perspective, we can observe our thoughts without thinking of ourselves as the “thinkers”; feel our emotions without being the one who “has” them; and when we act, we can realize that these actions are in one respect not really our own. It can be unsettling and confusing to realize the extent to which this perspective is true; in another respect, it can be quite freeing and can contribute to deep insight about human nature. It is the wisdom of non-self, of interbeing, of no boundaries, and of *emptiness*.

When I first took note of these ideas in the teachings of meditation masters, they struck me as challenging, a bit weird, arguable, and thought provoking. But what does this set of insights have to do with the practice of DBT? Everything. Whether we choose to notice it or not, the “beginning” and “ending” of therapy are difficult to define; the boundaries between patients and therapists, between patients and their social contexts, between therapists and their DBT teams, and between patient-therapist dyads and society in general are difficult to specify; and the answer to the question “Who did what to whom?” is more complicated than it seems. When the mental health staff of an inpatient unit complains that a certain patient is “manipulating us,” we can revisit the same circumstance with concepts of non-self, interbeing, and no boundaries. We realize rather quickly that the staff is supposedly in charge of establishing the conditions of the program, and that the staff, consciously or unconsciously, reinforces some patient behaviors and not others. It would be just as valid (but just as unhelpful) to argue that the staff is “manipulating” the patient to engage in certain actions by reinforcing those actions. Ultimately, the determination of who is manipulating whom becomes less meaningful and useful than adopting a transactional perspective in which both parties are considered responsible and collaboration between them is the preferred direction. In DBT, we are not so interested in who is manipulating whom, but determining how the behaviors of both parties are being reinforced.

In individual therapy, when my patient and I are at odds, not seeing eye to eye, and the session is charged with tension, struggle, or detachment, I can “drop down” from the conventional, self-oriented level of reality where I usually operate, into the place of no boundaries, no-self, interbeing, and emptiness. When I do that, everything shifts; I relax my conventional definition of what is occurring and see the interaction with the patient through a different prism. Where I saw a boundary between two independent, separate beings at odds with each other, similar to separate waves colliding in the ocean, I now see us as two interdependent forms, made of the same ingredients, both changing, both transient, each

one defined in part by its relation to the other. There is no boundary, no uniqueness, nothing separating us, we are simply there. We both have our strengths, and they become collective strengths. We both have our flaws, and they become collective flaws. I stop “doing” and instead I am “being.” I find it very hard to describe this different state, but it places our relationship, in that moment, on entirely different ground. It is a radical, immediate reconceptualization. I see us not as two people, each with his or her identity, at odds with each other; but instead as two parts of one entity, joined in some kind of unfolding narrative. By no means am I saying that this is “*the* truth.” It is “*a* truth,” a truth that is less conventional, more systemic, and that gives rise to a different approach. Through the prism of non-self, no boundaries, emptiness, and interbeing, we are all profoundly “in it” together.

One time my two young sons were fighting with each other over the control of the television remote device while I was doing something in the kitchen, very near to them. I was so aggravated by what seemed to me to be the senselessness and the unnecessary battle. My tolerance was growing short. I had the urge to repeat what I had typically done: to stand between them and the television, to raise my voice, possibly to turn off the TV, and give them a lecture about cooperating, caring for each other, or respecting that I might not want to hear their fighting. That is, I had the usual urge to “do something” about the situation, which usually had an unhappy outcome. They were “doing something” to each other, “doing something” to me, and then I would “do something” to them. But on this particular occasion, I dipped into the frame of “being.” I simply observed them; observed my own thoughts, feelings, and urges; and let go of my attachment to changing the situation. Then I walked over to where they were sitting, sat between them, and continued to just observe the dance of conflict that was going on. And as I sat there, just noticing but not “doing” anything, the two of them completely stopped fighting. They asked me what I was doing, and I said I was just being there, just noticing what was happening rather than telling them what to do. The impact was immediate: They both seemed puzzled and a little uncomfortable but calmer; they continued to watch television, and the conflict ended. It lost its momentum.

Temporarily letting go of the construct of boundaries and of self during psychotherapy, and dipping into the realm of interbeing in which patient and therapist are deeply interdependent with each other, can expose the therapist, through intuition and contemplation, to another level of data about the patient. In fact, conventional and rational thought might interfere with access. A young man was describing to me the terrible experiences he was having at a new job. He was given only minimal

orientation to a rather complex set of tasks for which he would be responsible, and had the impression that he should not ask many questions. Day after day, he felt overwhelmed. Faced with task after task, without the slightest understanding of how to accomplish them and without an avenue to get support, he felt that he was “going under.” He thought he was becoming depressed, feeling more and more as if he were stupid and incapable. Mostly, he felt very alone. At a certain point, as he recounted another difficult week on the job, I closed my eyes for a short while, allowing myself to “fill up” with his experience, as if it were my own. The boundary between us became permeable, and I had a deep sense of loneliness and loss. I imagined being him, being stranded without help. I recalled a study I had conducted during medical school, in which I observed toddlers in the hospital without their parents, for days at a time. My thoughts went back to my own history of hospitalizations as a child, being left alone to cope. And suddenly I remembered my patient’s history of having lost his mother to cancer at the age of 13. I then spoke: “I find myself thinking about loneliness and isolation, how terrible it can be to have to solve everything alone. And it reminds me that when your mother died, when you were 13, your relatives left you stranded with your little brother, and you had to figure everything out yourself. I wonder if this job situation has any flavor of that?” His eyes filled with tears and he went on to tell me more about the horrors of being stranded when his mother died. I think he felt understood, and when we returned to talking about the job situation, he seemed more resilient. To allow oneself to access the level of experience where boundaries go down and intuition goes up can add to the repertoire of the therapist with difficult-to-treat patients.

There is significant power added to our repertoires as therapists if we can move between two perspectives on the same predicament. From the perspective of the change paradigm, we act upon patients through assessment and change-oriented interventions, and patients act upon us by collaborating or opposing, making a commitment or not, carrying out assignments or not, and so on. This is the “doing” perspective at the core of the change paradigm, and it relies on the conventional understanding of self, other, and boundaries.

From the perspective of the acceptance paradigm, centered around “being” rather than “doing,” we see ourselves and our patients as interdependent beings, each one part of the other, boundaries uncertain or dissolved, united in the task of therapy, sharing space, time, energy, matter, ideas, intentions, and so on. In the “doing” perspective, there is a destination or a series of destinations; there is the power of purpose. In the “being” perspective, there is no destination; there is the power of being, or interbeing, in the present moment. Out of the change paradigm per-

spective flow the problem-solving strategies, the irreverent style of communication, and the insistence on working with patients to solve their life problems. Out of the acceptance paradigm perspective flow validation strategies, a reciprocal style of communication, and the willingness to intervene in patients' environments on their behalf.

Perhaps even more deeply, if you can “get the feel” for it, there is a different experience from the inside out, in the body and in the mind, between these two perspectives, each with its own power (and then there is the power of moving back and forth between the two, which is captured in the discussion of the dialectical paradigm). To experience yourself within your body when “doing” is different than the experience of your body when “being.” It might be the difference between leaning forward while pushing for behavioral change, versus relaxing the weight and substance of your body into the moment, into the chair, refraining from pushing. I am trying to convey that there is an experience, beyond the naming and employment of different sets of strategies, which differentiates the practicing of these two different paradigms. The internally felt experiences of “doing” versus “being” can ground you in the appropriate paradigm and set the stage for deep work on change or acceptance. The power and creativity of doing DBT effectively is to weave these two perspectives together in the service of helping your patients to build a life worth living.

IMPERMANENCE

One of the greatest challenges in treating individuals with chronic, severe emotional dysregulation arises when emotional arousal is at its most intense. The patient finds such emotions nearly intolerable and may react to them as if she is phobic of her own emotions. She has learned that a rapid escape into behaviors such as self-injury, violence, or substance abuse is an effective antidote, and she becomes trapped in a life punctuated with problematic behaviors. At the same time, by escaping quickly, again and again, in the face of emotional arousal, she acquires the belief that negative emotions are terrible, are static, and are permanent. Her rapid escapes prevent opportunities to learn otherwise.

On our inpatient unit was an 18-year-old biracial woman who was adopted by an older-than-usual Caucasian couple when she was 3 years old. Her own temperament, from the beginning, was difficult. She was moody, highly sensitive, and emotionally reactive. While her parents were devoted, kind, and generous with her, their rather laid-back, calm, low-affect intellectual styles were highly contrasting with her lively and

emotional style. It is an example of the fact that even a kind and devoted environment can be invalidating for a child due to a mismatch in temperaments. By the time she was a teenager she had begun to cut herself on a regular basis as a way to deal with intense painful emotions. Without cutting, she felt that she had no way out. In addition, she came to believe that these emotions would last forever if she didn't interrupt them.

Her DBT skills group had just begun a new module, the Emotion Regulation Training module. In the first session, the teachers presented a number of basic features of emotions. One of them was that emotional responses are in fact rather brief in duration if one does not continue to retrigger them with emotional thoughts and actions. As a practice assignment, patients in the group were invited to study "the life and death of an emotion" next time an intense emotion arose.

During the community meeting on the following day, she asked me if she could be on the agenda. When I called on her, she told everyone that "a miracle happened last night." She explained that during a conversation with her mother on the telephone she had felt hurt and intense anger. She hung up on her mother and was riddled with urges to harm herself. Then she remembered the assignment from her skills group. She decided to just observe her emotions for a while. She sat for a few minutes, walked around the unit, then sat again, all the while noticing her emotions. Not only did she find that her hurt and angry feelings waxed and waned, and changed in quality over the next 20 minutes, she also found that they faded away after that amount of time, at which point she hung out with some of her peers. Her description in the meeting was exciting, as if she was reporting a newly discovered human phenomenon—which is exactly what it was for her.

Yes, emotions are impermanent, if only we let ourselves realize it. So are thoughts, actions, and the situations in which we find ourselves. The recognition that impermanence is the nature of reality can be transformative. This can be particularly helpful for therapists who feel as if they are facing, in session after session, the same unchanging patient. Frustration grows and hopelessness sets in, in part because of the growing conviction that nothing is changing, when in fact that cannot possibly be true. As therapists, we are wise to learn from our young patient's revolutionary discovery.

As with the other insights discussed in this chapter, the recognition of the impermanence of reality also informs us as therapists deeply, subtly, and constantly. It can alleviate our distress, reduce our suffering, and keep us on track in DBT if we can simply accept that things are *always* in flux. What seems unchangeable or impenetrable is actually changing.

Every moment is fresh, in fact, despite the experience of both parties that it is old, unchanging, and stagnant. In Buddhism, the term *beginner's mind* refers to the experience that the encounter with each moment is fresh and new. Like a persistent wave in the ocean, every persistent problem represents a formation or sequence, which no matter how unyielding it may seem, is made up of constantly changing ingredients, in a constantly changing context. The wave may look the same, but it consists of another, and another, and then another collection of water molecules in constantly changing orientations. Understanding this basic reality, we can say with conviction, "This too shall pass." We become more patient, more resilient, more alert to missing variables, and we learn that the "boiling point" of change could come at any moment if we keep up the heat.

Another value of recognizing impermanence as a permanent phenomenon is the recognition that if things are going well today, they probably will change for the worse tomorrow, somehow. What goes up comes down, what comes down goes up, and if we can keep this reciprocal process in mind, we will be less "thrown" by the slings and arrows of misfortune. The patient says, "But if I make things better, they will just get worse anyway, and it will be devastating." Thinking about this aspect of impermanence, the patient then avoids trying to make things better. The therapist responds: "You are right. If things get better, they will probably, in some fashion, become worse, though never the same as before. It's just a law of the universe, and if we can accept it, we can experience the gains and losses on the way to a life worth living to be speed bumps rather than brick walls."

"THE WORLD IS PERFECT AS IT IS."

This is another one of those insights that can sound rather simplistic, alien, and impossible. How could the world be perfect, when in fact there is so much suffering, wrongdoing, conflict, and misunderstanding? How can we say that everything had to be as it is, that everything should be the way it is, that everything is perfect just as it is? How can a suicide attempt, a vicious assault, or a treatment failure be "perfect"? The statement can be confusing, invalid on the face of it, until we understand that the word *perfect* is not being used in a conventional way. "The world is *perfect* as it is" does not mean that things are OK, that the world is fair and just, the environment is compassionate and forgiving. It does not mean that we approve of the world as it is, or agree with it. It simply

means that the world is exactly as it is, exactly as it should be, given everything that came before. It simply means that everything is caused by what came before. Someone attempts suicide because, historically, leading into the present moment, all causes and conditions are in place to support the act of suicide. How could this moment be anything other than what it is, given the collective impact of all previous moments? This perspective is no different from the way a behaviorist thinks when assessing the controlling variables of a given behavior—that is, when assessing the causes and conditions that bestow a certain function on a behavior and maintain it.

Karma is a principle arising from Buddhism that rests upon much of the same thinking. It means that everything now was caused by prior deeds. Taking it one step into the future then means that we build our future deed by deed, by today's choices, thoughts, words, and actions. Every seed planted today has consequences tomorrow. Looking backward at how the current state came into being has to be balanced by looking at this very next moment, and all moments beyond it, in which current choices and deeds can bring about a different outcome. Finding this balance can help the DBT therapist freshly and hopefully push forward in a treatment of chronic and frustrating problems. Old deeds have brought about current outcomes; new deeds will determine new future outcomes. Things change; we plant seeds now so that new things will grow. Time may not “heal all wounds,” but it definitely results in change. For the therapist working with the difficult-to-treat patient, it can be rather comforting to understand that if she can persist at the practice of DBT through thick and thin, applying its multitude of guidelines and strategies, things will indeed change. In DBT, the therapist has things to do that may help her and the patient to outlast the pathology, which is transforming constantly.

This principle that the world is perfect as it is finds its way into DBT's treatment package in several “locations.” One of DBT's clinical assumptions is that, regardless of what may seem to be the case, patients are doing the best they can. Another assumption is that regardless of how patients appear to be undermining their own improvement, we assume that they want to improve. Patients may seem to be willfully and defiantly ruining their lives, ignoring their therapists, forgetting the skills, and doing the same self-destructive thing over and over again. How can they be doing the best they can? How can it be true that they want to improve? That is exactly the question at that moment for DBT. If you allow yourself to embrace the insight that “the world is perfect as it is,” it will seem simple to recognize the truth of the current dysfunctional

behavioral patterns; the truth that everything had to be as it is, given how it has been up to this moment; the truth that patients are doing the best they can; and the truth that they would like to improve. Then, in that moment, experiencing each patient with compassion and without judgment, the therapist can work with the patient to build a better life from that time forward.

The concept of karma finds its way into a third assumption about patients in DBT: Patients have to try harder, do better, and be more motivated to change. Even though everything is as it has to be, given everything that was, the future is not determined. Every behavior now has consequences; actions *matter*. With each action, each choice, each intervention, we are laying down stones for a path that will lead to the conditions of the future, hopefully to a life worth living. Recognizing that the “world is perfect as it is” and that we are, at every moment, laying the groundwork for the future can help the therapist to continue to “do DBT” even in the face of no immediate signs of progress.

CONCLUDING COMMENTS

I have articulated the principles of the acceptance paradigm and the practices that flow from those principles, as if they exist alongside, and in parallel with, the principles of the other two paradigms. But in practice, ideally, we are influenced by the acceptance principles all the time. As therapists, we establish and maintain a context of acceptance, within which we engage each patient in behavioral change leading toward a life worth living. We attempt to root our awareness and attention of our patients in the *present moment*, returning there again and again, as needed. We notice the ways in which patients’ *attachments* (to certain perceptions, beliefs, assumptions, moods, sensations, predictions, and so on) obscure their recognition of reality “as it is,” and then repeatedly attempt to help them let go of the attachments. We are informed by the recognition of the relentless *impermanence* of reality, the uniqueness of each moment, and the inevitability of change. Relaxing our investment in seeing conventional boundaries between ourselves and our patients, between any one person and all others, indeed between any phenomenon and all phenomena, we instead see the deep *interrelatedness* of all, the way in which all are one, and how in that respect we and our patients operate as one. Our ordinary convictions of the separateness of self and the uniqueness of identity gives way to a recognition that each of us is made up of all others, of all else. And in spite of the natural tendency to

impose judgments on ourselves and others, we yield to the understanding that, deeply, everything emerges in response to causes and conditions of past and present, everything is as it should be, everything is “*perfect as it is.*”

Influenced by these principles of acceptance, we intervene with validation strategies and a reciprocal communication style that includes warmth, genuineness, responsiveness, and self-disclosure. Ideally, we create and maintain an atmosphere in which safety, trust, and attachment emerge, providing corrective emotional experiences for all our patients.

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