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Rhetoric in Dialectical Behavior Therapy: Healing Minds Through Argumentation

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ABSTRACT

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The fields of psychology and rhetoric share the goal of improving human mental health and behavior through persuasion. This thesis traces the history of rhetoric and psychology theory, focusing on the parallel theories of Nienkamp's internal rhetoric and Herman's dialogical self. Both theories model the human mind as having multiple psyches that actively interact to interpret human experience and project human behavior. I conclude with a case study of anorexic patients using ethos, pathos, and logos in dialectical behavior therapy (DBT), arguing that principles of rhetoric can help patients with mental disorders cognitively realign their thinking more effectively than drug treatments can.

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Introduction: Can Words Heal Minds?

According to a study in the journal *Health Affairs*, mental healthcare—ranging from mild depression to severe psychosis and including disorders as diverse as addictions, obsessive compulsive disorder, and schizophrenia—earned the drug industry alone more than $146 million in prescriptions in 2004 (Silberner). That figure does not include therapy, rehabilitation, interventionary hospitals, treatment clinics, recovery programs, and a host of other related costs. Despite these costs, many therapists feel treatments are still inadequate, leaving patients dependent on drugs to dull physical symptoms, such as debilitating fears, obsessive behaviors, and erratic actions, but with the underlying problems remaining. Dialectical Behavior Therapy (DBT) offers an intriguing alternative—if we can't heal emotional disorders through drugs and treatments, can we heal them with words? Can talk therapy, a specific type of rhetoric, bridge a gap that the medical community has thus far struggled to cross? And if so, how? To answer this question, it's first helpful to look at recent neuro-research correlating mental and physical health.

Cognitive Studies in the Mind/Body Connection

Early treatments for mental disorders were often crude and unsophisticated, with little medical understanding of the causes of mental disorders or how those disorders manifested themselves physically. Alan Lickerman, an internist specializing in mental disorders, notes that early brain studies felt that the "mind" was located in the physical brain. Consequently, mental disorders were believed to be the product of a physical malfunction located in the brain. Therefore, mental or emotional stability was believed to best be treated as a biological case through drugs, and even early surgeries (Lickerman). This theory of the mind was supported medically, and physicians have been treating symptoms of emotional distress through drugs for years. Anti-depressants are used to relieve symptoms of depression. Anxiolytics such as Valium

can relieve anxiety. However, as pills have failed to *cure* troubling mental disorders and are increasingly found to be inadequate to relieve serious symptoms in cases such as schizophrenia, neurological research has expanded to study other external influences on the brain—influences even as far removed from drugs as words.

Lickerman cited a recent MRI study to note that "changes in thinking cause significant, measurable changes in brain chemistry and functioning," rather than the other way around. In the study, patients with spider phobias were observed to have abnormal brain patterns of excited fear when viewing a spider, causing them to scream or react physically. Drug relaxants could calm those reactions, but only temporarily. When the drugs had worn off, the patients would still scream on seeing the spider, with the same exhibited brain activity. However, after receiving a form of talk therapy (Cognitive Behavior Therapy), the brain activity returned to normal and when patients were shown pictures of spiders days later, brain activity remained normal with no sign of trauma. The patients used words to cognitively re-align their physical brain patterns, and the phobias disappeared (Lickerman). If the physical brain and the mind are so closely intertwined and treatable by non-chemical influences such as words, the implications are intriguing for anyone involved in the art of persuasion.

Cognitive studies today embrace the idea of the condition of the physical body being a product of both biological and environmental influences. Embodied cognitive research suggests that the mind and body function in holistic parallel; as the mind can be treated through the body, so can the body be treated through the mind. Fuchs, a cognitive scientist, explained it this way:

> Whereas traditional representationalism rests on the fixed inside-outside
>
> distinction, the embodied cognition perspective views mind and brain as a

biological system that is rooted in body experience and interaction with other

individuals. (Fuchs)

In other words, mental stimuli and physical stimuli have a reciprocal relationship. For example,

studies in embodied cognition have observed that imagined and visualized objects activate

physical cortexes in the brain. In monkeys and humans, the motor neurons involved in

controlling tools are active when pictures of tool use are viewed, even without overt motor

actions or planning (Rizzolatti and Arbib 188). Silent rehearsal of words uses the same

neurological structures as those for speech perception and production (Wilson 44). Others have

observed that abstract linguistic metaphors and mathematical entities are interpreted in the same

cortexes as those that process visual stimuli (Núñez 160).

This research has rich implications for the medical community and the treatment of

mental illness. If the mental and physical are so tightly connected, one could conceivably treat a

physical manifestation through mental treatment and vice versa. Previously, environmental

influences to be considered for a patient's physical health consisted primarily of diet and

exercise. However, research suggests that stress and emotions also play a large role in the

performance of our physical body. The implications of this are that words, pictures, and media

can then have a biological correlation—as words and rhetoric in many forms impact our

emotions and state of stress on a daily basis.

For some, this idea isn't new. Since Plato and Aristotle, rhetoricians have been intrigued

by how the mind works and studied how language can influence the mind to better health and

behavior. Aristotle, Cicero, and others studied the relationship between words, emotions, and

behaviors. What they discovered, long before neuro-scientists, is that many unpleasant or

undesirable behaviors and emotions can actually be influenced for good by words. Hence,

Aristotle advocated literature and theatre as methods of using rhetoric to teach good principles

for living, modeling the benefits and consequences of certain behaviors. Overall, the goal of a

rhetorician is to help society best live what cognitive philosopher Solomon referred to as "the

good life," whatever "a good life" means to that particular society (266). Rhetoricians seek to use

language to help people live better, acting from the belief that language has direct access to and

impact on core thinking, emotions, and resultant behaviors. The key difficulty rhetoricians often

face is how to put their theory into practical application. As it happens, some clinical

practitioners are already taking principles of rhetoric and teaching them as skills—these are

cognitive therapists.

Cognitive therapists share the same goal as rhetoricians, to help clients create a life worth

living through different forms of therapy—many of which involve words and talking, such as

Cognitive Behavior Therapy (CBT). CBT is a broad term for types of therapy that developed in

response to the theory of embodied cognition. One of the more prevalent forms of CBT is

Dialectical Behavior Therapy (DBT), which is a talk therapy that treats patients suffering from

eating disorders to borderline personality disorders through forms of dialogue. If rhetoricians and

talk therapists share a common goal—healing individuals' minds and behaviors through

language—what can a comparison between some of the primary theories and practices of

rhetoric and psychology offer to the study of the art of persuasion?

The project of this thesis is to examine the overlapping theories of therapy and rhetoric to

see what each can offer the other in practical application. This thesis will first look at key

theories of rhetoric and psychology for understanding the process of human thinking, comparing

parallel views of Nienkamp's internal rhetoric with the rhetorical self and Herman's view of the

dialogical self in psychological studies. This thesis will then examine how rhetoric therapy is

used in talk therapy, arguing that DBT therapists use the rhetorical toolbox of ethos, pathos, and logos to teach individuals with eating disorders how to heal their minds through healthy self-persuasion.

How Are Rhetoric and Psychology Related?

Michael Billig, in his study of the history of rhetoric and psychology, noted that in some ways, today's study of psychology came to fill a gap when rhetoric oscillated between argumentation and aesthetics in the 1400s and the 1600s, "During the Renaissance there was a pronounced shift from a persuasive rhetoric to an ornamental one" (82). Billig notes that from Caxton to Comenius, rhetoric was considered less a tool of argumentation than a form of aesthetic study, with less attention paid to its use for the logical forming of arguments and arrangement in content—points Aristotle labored much over. Today, emotion studies traditionally fall in the philosophy and psychology camps, and rhetoric is associated with speech writing, propaganda, and composition studies. However, even in speech and composition studies, emotion still has a strong hold in rhetoric, as audience reception is a critical part of rhetorical understanding. As Billig remarked, "The pragmatic side of rhetoric has always been closely connected with psychological issues" (82). He noted that successful rhetors need to study emotions, audience, the ways opinions are changed, and how words and the psychology of humans interact. Understanding the psychology of an audience is critical for effective rhetoric. Aristotle felt that successful rhetors must know what provokes anger, admiration, shame, and how different audience members are likely to react. (1378a 1-10). This valuable information presently "falls under the heading of social psychology" (Billig 84), which is precisely why rhetoricians must turn to psychology to recover part of their discipline, and why psychologists' work resonates with a rich, Aristotelian rhetorical history.

Interestingly, therapist techniques are rhetoric-rich—using and teaching persuasive tools of ethos, logos, and pathos. Many of the techniques therapists use and the coping skills they teach their patients relate directly back to Aristotle's rhetoric. Dr. Frank noted, "Psychotherapists use many of the same devices as rhetoricians such as vivid metaphors and sensory images to focus the patient's attention on ideas central to the therapeutic message and make the therapist's ideas more believable" (Frank 296). Rhetoric is useful to therapists precisely because it teaches effective thinking principles and skills for mentally coping with conflicting situations. Billig feels that all sources of rhetoric are useful for psychologists principally because they involve so much of how people think:

> It will be suggested that psychologists have overlooked the extent to which our inner deliberations are silent arguments conducted within a single self. If deliberation is a form of argument, then our thought processes, far from being inherently mysterious events, are modeled upon public debate. In consequence, the rhetorical handbooks, which provide guides to debate, can also be considered as guides to thought. (Billing 35)

If rhetoric is a guide to thought, and therapists work to teach patients new ways to think, that must come out in therapy and in practice, such as in types of cognitive behavior therapy (CBT).

Internal Rhetoric and the Dialogical Self

Rhetoric and psychology both share the idea that the internal being is composed of multiple, conflicting forces that in some way need resolution. Rhetoric's model is called internal rhetoric and psychology's model is called dialogical self-theory. Rhetoricians' model posits the model of an individual who has an internal rhetoric or text that the individual uses in daily self persuasion to healthy behaviors—an internal rhetoric negotiated by and edited through external

voices, influences, literature, and language. Kenneth Burke refers to this as a model of "parliamentary voices" (Burke 38). Wayne C. Booth further developed this idea in what he termed a "social psyche," explaining, "There is no such thing as a privatized, independent self bounded by a skin. The self is radically and inescapably a *social psyche*, made of many selves" (116).

In parallel, the psychotherapist model for CBT is contingent on the idea that the patient is composed of multiple psyches. Each psyche is built to meet the needs of different social situations and is responsible for different behaviors. The therapist works as a privileged internal member of the patient's psyche in helping the patient dialectically negotiate how those multiple psyches can best co-exist in a healthy manner that Hermans called the dialogical self. The idea of the self having multiple voices might not seem revolutionary today, but it certainly is a shift from prior psychological models that viewed the individual mind as a single entity. The following sections will look briefly at the rhetorical and psychological traditions to see where and when they began looking at the self as multiple—for that is the point of intersection that is of interest here.

Rhetorical Theory: Internal Rhetoric for Self-Persuasion. Rhetoric traditionally focuses on public narrative, but studies over the past few decades have shifted rhetoricians' focus from the public to the private sphere. The need for rhetorical skills in interpersonal relationships has increased as the occasions for public oratory have, to some extent, decreased. In her history of rhetorical studies, Dr. Robbins-Tiscione describes a shift from "a codification of skills" under Greek philosophers (10), to a "study of style" through Christian apologists (25), to a "methodology of truth" for elocutionists and epistemologists (43-45), down to the present-day studies in "cognitive rhetoric" (79) or "the art, practice, and study of human communication"

(61) by scholars such as Burke, Elbow, Toulmin, Perelman, and others. This pattern illustrates the shift from a scientific, public model to a humanistic, private model of connections and contextualization. The more recent focus on interpersonal rhetoric logically leads to an examination of the narratives that the self uses rhetorically.

Most people talk to—and even argue with—themselves on a daily basis. *I really should not eat that doughnut. Will I be late if I take the freeway? Come on, hold it together--you can do this. I just can't make up my mind; should I or should I not take that job?* Jean Nienkamp looked at this idea of internal dialogue between the multiple selves and coined the phrase "internal rhetoric" to refer to these inner dialectical exchanges of our psyches' multiple perspectives. Nienkamp argues for study of thought as a system of self-persuasion with implications for "other people" persuasion. She defines internal rhetoric as a Burkean "terministic screen…through which to study mental activity," rather than as a separate genre of study (Nienkamp ix). In her key work, she traces internal rhetoric from Isocrates in Greek literature through Kenneth Burke. She argues that internal rhetoric was originally conceived of by Plato as a dialogue between emotion and reason, with reason being the preferred member of the two. She also points to Plato's split between thought and speech, and Aristotle's failure to reconnect personal deliberation to his analysis of emotions and public oratory as the reason for rhetoric's present exclusion of internal dialogue and focus on external dialogue (xi). Nienkamp believed that after Freud the dialectic of reason and emotion developed into today's model of the inner psyche composed of multiple individual views, what Kenneth Burke would refer to as a "parliament" of voices "with conflicting interests expressed in various ways designed to take the claims of rival factions into account" (Burke 38).

Each person's internal rhetoric is unique because each person is a composition of individual nature and experience. Each internal rhetoric "is made up of a colloquy of internalized social languages" (Nienkamp 127), "voices" (128), or "cultural imperatives" (135). The rhetorical self practices internal rhetoric to "maintain a fragile equilibrium of personal identity and to resolve ambiguous or conflicting imperatives for attitude, decision, and action" (128). In other words, each of us has certain, unchangeable characteristics that determine what we do—our nature. Each of us also experiences multiple, competing social influences or voices telling us what we should do—our nurture. Internal rhetoric is the internal dialogue through which we negotiate those differences.

For therapists and rhetoricians, Nienkamp's theory implies that language begins its construction in the psyche, inwardly discussing and monitoring the construction of our daily interactions, rather than simply responding to external rhetoric or public venues. Internal rhetoric suggests our psyche is subdivided into multiple roles that are socially constructed by our emotional and biological heritage, our gender, religion, social settings, family, friends, choice of literature and media, and so on. For example, I have separate roles as a sister, a roommate, an employee, a daughter, a student, a teacher—multiple, equally valuable psyches inside me that will react in different ways dependent on which constructed voice is dominant in a given situation. Often the line is a bit blurry, and multiple voices engage in dialogue to gain supremacy. Bringing a friend home, for example, might require a negotiation of the role as "friend" and as "sister" and "daughter." I might be more polite than usual because a friend is there, or more liable to be irritable if a parent asks me to do something, since I am used to my friend viewing me as independent.

To use a concrete analogy, the dialogue of these voices can be seen as an "inner whiteboard." Our internal rhetoric is not static but organic; our emotional responses and inner beliefs are constantly re-negotiated on our whiteboard as the mind reacts to outside persuasions and re-evaluates beliefs and behaviors. This concept is crucial in therapy studies, especially for talk therapy like DBT, since it suggests that our belief systems are changeable; and individuals with harmful belief systems, such as someone who is suicidal, have the human ability to change that belief system. A pill cannot keep someone alive who is determined to die, but persuasion might.

Psychology Theory: The Dialogical Self. As mentioned, Nienkamp's groundbreaking work on internal rhetoric points to a shift in rhetoric studies from the public voice to the private voice and from a linear cause/effect model to a holistic model. Historically, therapy theory follows the same construct. The British Film Institute's research on disability in the media notes that in the past, patients with mental disorders were treated with the "public voice" of reason, where prevailing medical and religious doctrines were applied equally to a broad spectrum of disorders through "moral treatment" or the "medical model." Moral treatment developed in the eighteenth century and reflected the belief that mental patients were individuals who had lost their reason and, like wild animals, needed their moral compasses redirected through harsh "training," and often religious instruction. The medical model focused on diagnosing people against a set of "normal criteria" and looked for ways to adapt patients to a "normal life," such as using sedatives or containment methods, rather than considering individual histories and abilities ("Ways of Thinking"). Today, developments in psychotherapy methods have pushed mental treatments from a mass, public-voice applied treatment to a private client/therapist relationship that privileges the private experiences of an individual.

When did this shift occur? In her history of the development of therapy rhetoric and the focus on self-help, Cloud locates the rise in talk therapy in the wake of WWII, noting that the shift to a rhetoric of personal responsibility developed in conjunction with a reaction against public responsibility. The anti-communist agenda at the time also pushed a shift towards individual empowerment, which in turn resulted in a proliferation of self-help books and psychotherapy studies. As Cloud describes, "The word self-help itself suggests the intensification of liberal discourses of self-reliance and personal responsibility since the turn of the [twentieth] century" (Cloud 30).

This shift from public to personal responsibility has contributed in pushing therapy techniques from a scientific cause/effect model to a humanistic holistic model of contextualization. The traditional therapist observed the patient and offered corrections based on objective scientific reasoning of symptom x requires prescription y, whereas present psychotherapy methods work from a collaborative model of the patient and therapist as co-equals exploring interpersonal connections (Merkin), or in other words, "dialogues that lead to synthesis" (Diemeff 12).

However, a shift in treatment methods required a new model in psychology studies for how to understand human thinking, emotions, and behavior. The model of the mind acting as a single entity in reaction to its environment was no longer adequate to describe human interactions. Freud famously brought together medicine and psychology to construct a more correct understanding of the human psyche as one having multiple pieces. In many ways, Freud performed the first "mental dissections" needed to create an early crude understanding of human psychology. Using Freud's work, Dutch psychologist Hermans developed a model he termed "the dialogical self."

The dialogical self emerged at an interface of two traditions, William James' American Pragmatism and Mikhail Bakhtin's Russian Dialogism, and suggests that dialogical relationships are not just between individuals, groups and cultures, "but also within the self of one and the same individual" (Hermans and Dimaggio1). Typically, the self is thought of as internal concept and dialogue is an external process between two people. However, the concept of the dialogical self fuses the internal and external to better model the complex nature of human thought. Hermans argues that the individual can be both "subject and object" expressed in both multiplicity and unity (Hermans and Dimaggio 45). The self can be "extended" into space and time through multiple, imagined characters (Hermans and Hermans-Konopka 2). The self does this instantaneously and without conscious thought. The "other" is completely internal, and can be difficult to distinguish from the self. Multiple selves can disagree as well. For example, my working self likes going to work, but my lazy self would much rather stay home and eat frosted flakes in bed at 11 a.m.

A neurological research team creating a model of Hermans' theory offered a typical example of a woman with an internal parent/child model. A woman named Yvonne has arrived at work early for a special presentation. She is completely confident, prepared, wearing her favorite skirt, and rummaging in her bag for her back-up disk. She then finds her son's homework assignment for the day. Her mood drops as she realizes that he will be marked down for her error. Her thoughts begin running through her mind, "I can't help it. It's not my fault." To which her inner self says sarcastically, "Oh? And whose fault is it?" In this example, the research team suggests that the internal monologue comes from the orbitofrontal cortex and nearby premotor systems attempting to model a scenario the same way Yvonne learned to do verbally as a child. She has, in this example, created an internal parent self and a child self (Lewis and Todd

46-47). This model of internal dialogue reflects the model of internal rhetoric Nienkamp proposes, and suggests that everyone creates multiple psyches as part of their normal development; however, the ability of those psyches to be flexible and help individuals have healthy perspectives on situations depends on that individual's development and educational opportunities.

Hermans notes that the process of conducting internal dialogues develops in most children in their first few years when they develop the ability to have joint attention, to see things from multiple perspectives through reading, and through learning the principles of self-reflection (Hermans and Dimaggio 12). In this way, individuals consider problems or scenarios in an inner dialogue the same way they might have an external dialogue with another person. The self is not just an isolated entity, but similar to rhetoric's view of the internal self as a parliament of voices. Psychologists view the self as one constructed of multiple voices in dialogue that attempt to synthesize dialectical viewpoints from emotional and logical input in a given situation to determine best courses of action and understanding. In the example of Yvonne, she received information on one hand and processed it with accompanying emotions in a dialogue in her head, which helped her script her response to the situation. However, the entire process is so innate that we are largely unconscious of it. That said, not all individuals have developed healthy methods of internal rhetoric and reasoning. Whether through a neurological imbalance, an abusive situation, traumatic experience, or lack of education—some just do not learn to have healthy internal dialogue. Often, patients diagnosed with mental disorders are taught to sedate symptoms or forced to adopt new behaviors, instead of dealing with the mental stressors aggravating the condition. Whereas previous medical options offered little choice for individuals, new therapy techniques offer an alternative for individuals to deal with root cognitive causes—e.g., for

treating individuals with eating disorders—through talk therapies, such as Marsha Linehan's DBT.

DBT is a highly successful form of talk therapy that teaches patients effective skills of self-persuasion as a therapist talks through a patient's experiences from emotional conception to behavior. DBT is particularly unique in that it is successful long-term with some populations (such as persons with eating disorders or with borderline personality disorders) who typically have a high risk of relapse (Linehan 3-5). Instead of treating the behavior, or "external rhetoric," DBT works to get at the internal beliefs negotiated through "internal rhetoric." Words are key to DBT, as DBT is based on the idea that individuals have linguistically negotiated emotional intelligence (where emotional intelligence is understood to mean an individual's ability to identify, access, and use emotions in a healthy, productive way). The goal is for individuals to be able to calmly recognize negative situations—not to be overwhelmed or hide from them—and make wise decisions about what action to take instead of having paralyzing and often destructive emotional reactions. Using these skills, patients can develop "a life in which one wisely manages emotional conflicts in conjunction with one's most heartfelt values" (Solomon 268).

Dialectical Behavior Therapy (DBT): Rhetorical History and Application

The next section of this thesis will explore key rhetorical concepts from Protagoras and Aristotle that have laid foundations for Marsha Lineman's main theory for DBT:

1) Truth is found through **dialectic synthesis** of opposing viewpoints.

2) Individual patterns are understood through understanding **general patterns**.

3) Individual problems are solved through **applying general skills**.

After looking historically at the concepts of dialectic synthesis and general patterns, this thesis will conclude by examining three types of general rhetoric skills that are used in negotiating a

successful therapist-patient relationship. These skills come from Aristotle's three types of rhetorical appeals: ethos, pathos, and logos. Although DBT is used to treat a variety of mental disorders, especially borderline personality disorder, for simplicity all example patients in this analysis will be patients dealing with eating disorders, a mental condition estimated in 2002 to impact up to 24 million individuals in the US alone (Noordenbox 15).

Rhetorical Tradition of Dialectic Synthesis: Protagoras

Although Lineman traces the dialectic tradition only to Marx and Engels (Linehan 28), the principle of dialectic comes from a rich rhetorical tradition from the early Greeks. Dialectic refers to a movement of mind in search of truth: truth is found by comparing one side to the other—commonly referred to today as the "pros and cons" method—in order to find a middle ground. It is a type of thought originating in Greek philosophy that focuses on **developing** truth through movement between opposing points—a stark contrast to Western philosophy's general belief in **discovering** permanent, pre-established truth. Though the dialectical tradition is often traced to Socrates, the idea of dialectic came from earlier pre-Socratic philosophers, including Heraclites, Zeno, Parmenides, and Protagoras. In particular, Protagoras (490-420 BC) was famous for his—at the time controversial—legal style of discovering truth through verbal dialogue. Billig notes, "Protagoras was the first person who asserted that in every question there were two sides to the argument exactly opposite to one another" (71). Though earlier sophists promoted dialectical thought, Protagoras was the first sophist to argue for dialectic discussion in a legal contest, contending that every statement has a valid counter statement and that truth can be relative and subjective—a radical notion in a society that felt the universe was based on objective truths. This concept of truth as relative is critical for Lineman's model of successful therapist-patient dialogue.

The key underpinning of DBT theory is the principle of teaching patients cognitive flexibility by learning to find truth dialectically—which Lineman calls the principle of dialectic or synthesis. Patients coming into a therapy setting typically have deeply ingrained, harmful beliefs that promote negative behaviors. Typically, these patients have been sent to therapy because of their behaviors, since those are the only visible sign others have of damaging core beliefs. Core beliefs embrace truths that clients have cemented through personal experiences, and they are extremely difficult to change. Attacking core beliefs is as ineffective and potentially damaging as clearing ice off a windshield with a hammer. Rather, therapists use a method of gentle heat, teaching patients to put their thoughts in context, melting the ice into water and reconsidering their core beliefs. In therapy, patients are continually encouraged to understand their core beliefs as having a thesis and an antithesis (a concept unfamiliar to most), never accepting a truth without first examining the world that it came from. As Linehan describes it:

> Dialectical thinking is the "middle path" between universalistic thinking and relativistic thinking. Universalistic thinking assumes that there are fixed, universal truths and a universal order to things. Truth is absolute; in disagreements, one person is right and one person is wrong. Relativistic thinking assumes that there is no universal truth and that the order of things depends entirely on who is doing the ordering. Truth is relative. . . . to the eye of the beholder. (121)

Lineman notes that patients with mental disorders often have difficulty maintaining the cognitive flexibility to embrace a dialectic truth at first—they either believe there is only one right or no right answer. Part of their emotional panic and resulting destructive behaviors comes from the emotional inability to employ a "middle path" way of thinking—teetering either to universalistic or to relativistic thought structures. As Protagoras felt truth could only be found in synthesis of

multiple, valid viewpoints, so DBT attempts to teach patients the skills of discovering truth in situations by considering multiple view points. How these dialectic skills are actually taught is a point that will be discussed later in the paper. For the present, it is sufficient to sum up this discussion with a simple analogy: dialectic is considering the opposite sides of a coin in order to understand the whole coin or present truth, which brings us back to Aristotle and Linehan.

Contextualizing General Patterns: Aristotle and Linehan

In addition to seeing both sides, it's important for patients to learn to recognize patterns in their lives. In their writings, Aristotle and Linehan both describe a common goal—seeing the individual by understanding the collective whole. In the context of rhetoric, Aristotle argued that to be most persuasive, one needs to have a good grasp of government, the types of people, their customary practices, and what is advantageous to them (1366a 15-20). Remarkably similarly, Linehan quotes, "To understand the way the person creates the world, we must also understand the way the world creates a person" (Linehan 33). For Aristotle, in order to be persuasive to a particular audience, one has to understand that audience's core beliefs, how those core beliefs were formed, and what prompts people to action, or "the sorts of things that all people in common discern in some manner" (1354a 1-10).

To apply familiar rhetoric terms, the whole range of character (ethos), passions or emotions (pathos), and patterns of reasoning (logic) need to be understood as general patterns of human thinking before individuals can apply those general patterns to an individual's persuasive situation. Aristotle felt that if a rhetor looked too narrowly at an item of human behavior without context, the rhetor could well miss critical persuasion possibilities for influencing an audience. However, by studying the "big picture" concepts (such as how humans use ethos, pathos, and logos), rhetors can contextualize individual human events and better have "the power of

seeing…the available means of persuasion" (1356a 25-35). For example, patterns of human behavior have demonstrated that humans will typically act differently in a state of anger than in a state of calm, which means that an angry individual will likely require different methods of persuasion than a calm individual. Though Aristotle wrote his theory about general patterns directed towards other-persuasion to a large audience, the same principle applies to self-persuasion on an interpersonal level in DBT.

DBT also promotes using dialectic truth to create a big picture for patients, looking past events to larger emotional structures of "core beliefs." The term "core belief" is an important one in DBT. The conceptual idea is that patients are so focused on small events in their life that they fail to recognize how events are parts of patterns coming from core beliefs. And the only way to reverse the negative events is to find and reverse negative patterns built on certain core beliefs. Therapy sessions and journal assignments teach patients to contextualize every event in light of its "triggers," reconstructing the emotional history that led to each behavior. Behaviors typically spiral from a build-up of influences and events that create sets of core beliefs. Core beliefs— particularly in eating disorders—rarely stem from a "one-time" event, but from layers of influences and emotional points. Those core beliefs cannot be taken down without knowing how they were built first.

For example, anorexics typically hold a set of core beliefs that cause that individual to refuse to eat enough calories, typically believing that their actions are healthy. Although each set will vary, the following are common core beliefs a therapist can anticipate:

(1) Thin is the only form of beauty.

(2) I am more accepted and loved if I am more beautiful.

(3) I am a better gift to those I love if I am beautiful.

(4) My body is only healthy if it is beautiful.

(5) Not eating and hours of exercise are required for my body to be healthy, as defined by "beautiful."

(6) My behaviors are healthy for me.

Outside of physical image core beliefs, anorexics often have additional emotions related to control, such as:

(7) I can't control my boyfriend or my Dad, but I can control how much I eat.

(8) I don't deserve to eat because I am not a good enough person.

As heartbreakingly wrong as they all are, these core beliefs are poignant to each anorexic girl. As rhetoric was developed to deal with the complexities of human nature, which do not directly react to scientific laws as plants and rocks do, so each eating disorder stems from a complexly different human situation. Every eating disorder is different. In the case of anorexics, even if two girls display the exact same behaviors, the sets of core beliefs were formed in different ways, such as comments from friends or family members, media, interpersonal situations, perfectionism, or other anorexic friends. Competitive situations such as athletics—particularly dance, ice skating, or gymnastics—can also contribute. There are so many potential points that formed a core belief that therapists cannot offer a "one size fits all" treatment. However, therapists can help each individual sketch out their emotional history and re-align their negative patterns and behaviors with general patterns for healthy behaviors. Each went through a different emotional journey to get to where they were, and each will have to go through a personalized journey to get back.

Patients learn not to take a moment as a synecdoche of a whole (Linehan 36), but to embrace a broader perspective. As Linehan described it, "Dialectical thinking requires the ability

to transcend polarities and, instead, to see reality as complex and multifaceted; to entertain contradictory thoughts and points of view . . . to be comfortable within flux and inconsistency" (121). A therapy situation gives the patient an opportunity to have just such an experience with the therapist, recounting the patient's life's emotional development, considering the thesis and antithesis of conflicting core beliefs, and then applying skills of persuasion to synthesize a new, healthy emotional paradigm.

Although opinions about theory's purpose differ, I feel theories are only as good as their application. Although this paper is too brief to consider all the ways DBT and rhetoric are comparable in theory, hopefully this analysis has provided a framework. Key crossover points include the following:

- Rhetoric points to a dual self with a dialectic internal voice, whereas DBT works from the belief in a dialogical self—a self constructed from multiple influences and parts of life.

- Rhetoric and DBT both believe in truth found through synthesis and dialectic discovery.

- Aristotle believed rhetoricians are only as successful as they are at understanding general patterns of human behavior and history, and Lineman believed that therapists and patients are only as successful as they are at constructing an emotional history behind present core beliefs.

Applying General Skills in a Therapy Situation: Ethos, Pathos, and Logos

Theory aside, how do rhetorical skills show up in practical application in DBT? The remainder of this paper will look at Aristotle's three types of persuasion—ethos, pathos, and logos—applied to DBT counseling for eating disorders. Although this analysis does not tease

apart all the areas in which rhetoric feeds into a DBT setting, it categorizes some of the key elements.

Ethos: Building the Therapist Relationship and Patient Self Trust

As a rhetorical appeal, ethos is convincing the audience of the rhetor's character. How does that apply in DBT? There are two key ways: (1) the therapist must use ethos to convince the patient of the therapist's character and (2) in the context of the patient as a dialogical self composed of both rhetor and audience, the patient must build up self-credibility (or self-ethos) to be able to trust his or her own decisions again. The latter particularly applies to anorexics, who notoriously do not trust themselves and develop elaborate rituals or patterns to enforce self-discipline or self-punishments for perceived weaknesses.

The Value of an "Internal" Trust for a Therapist. Building credibility can be a complex process that will make or break a therapy relationship. Aristotle noted that a trustworthy speaker is essential, for "character…has in it just about the most decisive means of persuasion" (1365a 10-20). Linehan echoes that when commenting on the importance of the therapist/client relationship: "The relationship with the therapist is at times what keeps [the patient] alive when all else fails . . . . Not much in DBT can be done before this relationship is developed" (Linehan 98). The relationship is pivotally important because a therapist becomes not just an "outside authority" for the patient, but an "inside authority." The credibility is not built through degrees or certifications, but through an interpersonal relationship in which a therapist proves through dialogue their dedication to the patient's long-term health. As mentioned, DBT works from the context that the individual psyche is made up of multiple voices. To be effective, the therapist must win a privileged position of trust *inside* that negotiation. As one recovered anorexic, interviewed anonymously for this project, explained:

> I was swimming in a sea of competing ideas and voices in my head. I'm not
> crazy; I just didn't know what to believe. [My therapist] came in like another
> voice in my head, but one that I trusted enough to hold on to. He got louder, and
> louder, and together we made the other voices be silent, until I found serenity
> inside. (Anonymous)

Anorexics typically have strong internal self-critics, and those self-critics can't be removed at once. For a time, the outside voice of a therapist functions as an internal voice of reason, an ally in facing internal critics.

Therapists serve almost as an editor, helping the patient both read their internal narratives (typically through questioning) and externally reconstruct them. In this process of externalizing internal narratives, "the therapist highlights the inconsistencies among the client's own actions, beliefs, and values" (Dimeff 11). Once narratives are externalized, the client further privileges the therapist's participation by discussing those inconsistencies and making "cognitive modifications through conversations" (10). It's a very private, yet very open relationship that is essential for effective treatment. As Dr. Frank describes, "In therapy, patient and therapist collaborate to recall and reorder the patient's past experiences in order to create an apologia that sustains a better self-image and a more hopeful future" (Frank 297). Re-building an apologia often involves a very invasive examination of the anorexic's core beliefs. Sifting through those emotions and beliefs can be excruciatingly painful, and without a healthy ethos between the therapist and patient, the two cannot compose a new internal harmony for the patient.

Building Self-Ethos Through Validation. At some point in the therapy relationship, the patient must move from relying on the therapist and learn to accept his or her own internal ethos. Building self-ethos is usually a very difficult and complex process. Patients typically have very

low self-esteem and do not trust their own sense of reason. Instead, anorexic patients often have very elaborate rituals and punishments to "control" their internal, misbehaving self. As Linehan described, "The patient cannot trust his or her own emotional reactions, cognitive interpretations, or behavioral responses. Mistrust and invalidation of one's own responses to events, whether self-generated or coming from others, however, are extremely aversive" (Linehan 222). This is why, for a time, an anorexic will rely on the therapist to understand his or her secrets and to voice thoughts the patient feels forbidden to feel or say. Aristotle said that we trust "decent people" (1356a 10-15) who we believe have good judgment. In order to trust their own judgment, patients need to learn to see themselves as decent people. The primary way a therapist teaches a patient to have this self-ethos is through one of the core principles of DBT: validation.

Validating a patient is a tricky business and can be incredibly difficult. If not careful, a therapist may validate the patient's worst fears or suggest that the patient is incapable of handling something. There are typically three steps to full validation, which illustrate moving the circle of credibility from the therapist to the patient. First, the patient opens up trust in the therapist, and the therapist does "active observing" of the patient's words, underlying emotions, and the situational context of the topic of discussion. Second, the therapist "reflects back" to the patient what the patient said, emotionally and verbally. As Linehan describes, "In reflecting, the therapist often states what the patient observes but is afraid to say or admit" (224). That process of reflecting validates for the patient that their experience is real and trustable.

The third or final step is direct validation. The therapist looks for the wisdom or validity of the patient's response, and validates it back to the patient—even if only a small part of the response, behavior, or attitude under discussion is valid. By validating the patient, the therapist teaches the patient to trust himself or herself as a "decent person" with good judgment. As the

patient gains confidence, the therapist steps back from being a trusted internal voice and re-positions himself or herself as a trusted external friend. Effective ethos is trust, trust teased out through work, tears, and validation, giving patients the tools to find "a nugget of gold in every cup of sand" (Linehan 224) and change universalistic cognitive structures to healthy dialectic synthesis. This brings us to a discussion on the type of logical thinking skills a therapist teaches—or, Aristotle's principle of logos.

Logos: Building a Dialectic Viewpoint

For Aristotle, the persuasive skill of logos is a way of prioritizing viewpoints. As Rahe, a historian of Greek philosophy notes, Aristotle felt logos "makes it possible…to perceive and make clear…through reasoned discourse the difference between what is advantageous and what is harmful" (21). When it comes to the process of reasoning, most anorexics are actually highly logical. If asked to explain a behavior, they can usually provide a very rational answer from a certain point of view. The problem is that their logic is highly skewed to their individual perspective, often a harmful one. Logos comes into place when therapists attempt to teach patients to not only flex their cognitively cemented perspectives into dialectic viewpoints, but also to be able to logically evaluate which view point is valid. DBT teaches patients that even though there are multiple "rights," there will be one that will benefit the patient more than others. Typically, this involves teaching patients two logical skill sets: (1) Many "rights", embracing the idea of multiple forms of truth as equally valid; (2) Synthesis, evaluating those truths not as "right or wrong," but rather, best for that particular experience.

Many "Rights." The hardest argument for an anorexic to accept at first is that there are multiple "rights." In some ways these patients are Platonists—insistent on there being one realm of exact truth, or one right, that they must discover and embrace. As Billig, a social scientist

commented, "Unlike Protagoras, Plato wishes to transcend this world of opinion, in order to discover the fixed essences of truth…a vision of undisputable truths" (74). After all, patients tend to find things easier to control with one set of right answers to follow. Therapists, however, tend to try and convert them to Aristotelian logic of plurality in truth, which embraces a rhetorical world full of contradictions, shifting opinions and impressions. Aristotle argued that in both rhetoric and dialectic, "We should be able to argue on either side of a question; not with a view to putting both sides into practice—we must not advocate evil—but in order that no aspect of the case may escape us, and that if our opponent makes unfair use of the arguments, we may be able in turn to refute them" (1355b 10-25). To Aristotle, the point of argumentation was to not only present truth, but to find it by constantly considering multiple perspectives.

Therapists use a variety of techniques to help patients learn to appreciate multiple perspectives. These techniques include offering paradoxes, metaphors, playing devil's advocate, and "extending" or exaggerating the patient's perspective to point out the flaws that the patient is too close to see (Linehan 204-213). These methods teach patients to mindfully observe a situation, rather than focusing on controlling it, in order to see both sides. The perspective needs to "move from either-or to both-and" (204). The purpose of teaching dialectic thinking is not just improving the patient's skills at writing a pro-con list. Once patients become comfortable embracing multiple perspectives, therapists teach patients to logically synthesize those options to each find his or her own constructed ideal realm of truth.

Synthesis. Synthesis is a key principle of effective internal rhetoric. Nienkamp suggests that to some extent all of us have somewhat hardened cognitive extremes, and when we cultivate a healthy internal rhetoric, we are then empowered to act. She describes the "action" skills of *kairos* and *phronesis*—recognizing and judging wisely. The skill of *kairos* is the skill to

recognize and understand significant moments in context. The skill of *phronesis* is having the practical wisdom to make ethical decisions by applying principles in context (Nienkamp 133). She notes that in today's society, every individual's rhetorical self "encompasses numerous cultural paradigms for action and attitude" (133). Using internal rhetoric, an individual can mentally enact multiple scenarios to weigh the multiple perspectives, by entertaining a variety of ethical and cultural imperatives, by testing claims and predicting consequences from a variety of viewpoints.

To put this more succinctly in a therapy context, therapists aren't trying to convert their anorexics into complete relativists, but into intelligent thinkers who can intelligently evaluate options and make logical choices. As a therapist might explain, "Yes, there are many rights, but *one* of those will be more right for you, and only you can discover what that is." An example of the principle of synthesis can be seen in the following scenario of an anorexic and eating a cookie. Many anorexics have strict views on sugar as "bad" and something that is never okay to eat. There are rules against that. However, there are really multiple truths at play. Yes, it is true that cookies are not technically healthy for a body's physical needs. However, one cookie will not make a person fat. Also, a cookie could be very healthy from the perspective that there might be emotional satisfaction, friendships, or good memories involved in eating that cookie. From these valid viewpoints, the patient can see that there are multiple rights. The correct choice will depend on that scenario, rather than the hard and fast rule that a "cookie is bad." If the patient would simply rather not have a cookie because the patient was already satisfied, that's fine. But if the patient would like a cookie to enjoy with a friend, that's fine too. Having that cognitive flexibility is a huge step for anorexic patients. In order to reach synthesis and a "right" for that patient, the patient needs to accept that there are multiple valid options. Not so much "one bad"

and "one good," but a complex set of often equally good ones that can be negotiated to that patient's best advantage.

This brings us to our discussion on emotions and pathos. As key to teaching a logical dialectic, therapists also teach patients to embrace a dialectical emotional perspective—as both logic and emotion are needed in a persuasive internal rhetoric. Although viewing multiple perspectives logically can be challenging, adding the emotional component is often much more difficult, but is perhaps the most important.

Pathos: Creating a Dialectical Emotional Perspective

Aristotle and Cicero were both very interested in emotions and their influence on our critical decision-making. Although Plato described emotion as always inferior to logic in the rhetorical construction of truth, Aristotle felt that emotion was an important part of our human intelligence and experience, and described it as—if not quite equal to pure logic—still of high importance. Nienkamp noted that following Aristotle, Bacon, and Shaftesbury, moral sense philosophers, argued that "rational and rightly directed emotions are crucial to moral reasoning" and for cultivated internal rhetoric that leads to effective decision-making (132). Of the three canons, pathos (or emotions) arguably is one of the most studied parts of psychology today and hence holds an important place in therapy. DBT similarly privileges emotions in the construction of our thoughts, ideas, and beliefs. It is crucial for patients to learn to recognize what each emotion is and how it contributes to his or her healthier being.

The key to using emotions rhetorically in DBT is learning to use ALL emotions, not to paralyze us, but as strategies for living and negotiating this world. This is a different approach than other forms of behavior modification theories, which typically focus on "replacing" all negative emotions with positive ones. DBT takes a different, all-inclusive approach, teaching

that logic isn't possible without emotion, and burying an emotion rather than using it is as effective as weeding a garden with a lawnmower—not really getting to the root of the problem. Regardless of whether the emotions seem "logical" at first blush, patients are taught to first accept their emotions as valid, not fancies to be suppressed based on outside opinion; and second, to learn to welcome emotions as tools in directing our human experiences and actions. Cicero himself noted that while all emotions are in control, simply insisting they don't exist—as the stoics did—is incorrect. We have emotions; we just need to be intelligent about them. Every human experience is lined with emotions, emotions that come from the brain's attempt to understand, respond to, and engage with the world. To be logical, we must also be emotional.

Validating Dialectical Emotional Experience. Earlier in this analysis, we looked at the importance of logical validation in DBT and teaching patients to validate different perspectives. Equally key is emotional validation, which encourages patients to feel and use all their feelings, instead of fearing and compartmentalizing them. Just as anorexics tend to label certain beliefs or actions as "good" and "bad," they also tend to label emotions as "good" or "bad." DBT teaches that there are no "bad" emotions, just emotions that influence us differently. Aristotle noted, "We give very different decisions under the sway of pain or joy, and liking or hatred" ("Rhetoric" 1.2, 1356b 10-20). Because different decisions will seem logical under different emotional perspectives, it's important to include emotion in the process of analysis and synthesis.

A key point to understanding emotional experience is embracing the notion of a dialectical emotional experience. Solomon noted, "Emotional experience is best described in terms of the way the world seems to, and is grappled by, the person having the emotion" (234). Thus, each person may see the same situation and experience it differently. This is important for the patient for two reasons: First, the patient must accept that his or her emotional experience

may differ from that of others but can still be valid for the patient; Second, the patient must understand that what the patient sees as valid may be different than what another sees. Thus, in understanding self and others, patients need to include a *dialectical emotional perspective*, looking at things from additional emotional perspectives to understand the different consequences or facets of a decision or situation.

For a simple example of dialectic emotions at play, Linehan describes a scenario where an anorexic was insistent that her mother hated her and thought her fat as a teen. She recalled an instance years prior when her mother told her not to take a cookie from a jar. The emotions the teenager felt were anger and rejection, assuming that her mother's request was a judgment and that the child was too fat for another cookie. In contrast, when asked about it, the mother could only recall that the cookies were intended for something else. The mother didn't understand why her teen got so moody, was annoyed at her teen's response, told the teen not to be dramatic, which only confirmed the teen's assumption that her mother disliked or disapproved of her (Linehan 36). In this situation, the therapist and anorexic could discuss that multiple, equally valid emotions are at play here. The teen was right. Although the mother would argue that her child was illogically upset, the anorexic in question had valid reasons from her perspective for being angry. Just because the mother did not see it as a big deal doesn't mean it wasn't to the client. However, the mother was also right. She did not hate her child or see her as fat, or even give her a reason to be angry. She simply told her the same thing she would have told anyone assaulting the cookie jar. From understanding the whole view, the patient is then empowered to logically continue to be angry with her mother, or to let understanding erode her anger. Situations discussed in a therapist-patient setting are typically more complex than this example,

but it illustrates the key principle DBT teaches patients—the equal weight of dialectical emotional experience in any given situation.

Emotions as Tools. Although the complex range of emotions limits a thorough discussion on all the ways emotions can be used as tools, it's helpful to walk through the concept with one emotion, such as fear. Fear is one of the most prevalent emotions anorexics battle. Anorexics often fear themselves, fear food, fear fat, fear judgment, fear people, fear relationships, and even have fear of fear itself. This typically gives therapists and patients a knotty tangle to unsnarl, but let's look at the basic concept of fear first.

Cognitive philosopher Solomon describes fear as a tool of the mind. He notes that fear as an emotion is the brain's instinctual recognition of danger. Whether from first- or second-hand experience or simple tagging of the unknown possibility, the mind associates danger tags or "fears" with certain situations. Interestingly, individuals with damage to the parts of their cerebral cortex that experience fear are more likely to be taken advantage of because they have a limited capacity to recognize danger (29-31). For a simple example, being confronted with a dark alley would be a fearful thing to many people, and with good reason. Even if that individual had never had a negative experience in a dark alley, second-hand experience through media and stories has spread the idea that a dark alley can be a dangerous place, as it's dark, concealed, and ideal for a targeted crime. Caution is advised, and fear has been a useful tool in that situation. Fear as an emotion then is not irrational, but a highly logical and necessary part of our reasoning and intelligence. The question becomes then, what "danger tags" have I built up and which ones do I want to keep going forward?

For an anorexic, this can be a complex question. For example, to refer back to our example of an anorexic's fear of a cookie. Why has the anorexic made the association that eating

a cookie is dangerous? What negative experiences prompted that tag to be made? And is that tag useful for that anorexic in the future? If the anorexic, for example, had a gluten intolerance (as many recovered eating disorder individuals tend to have), keeping that danger association might be in that anorexic's best interest. If, however, that danger tag or fear kept that anorexic from going to a social event that would otherwise be enjoyable, perhaps that is a tag or trigger that should be removed.

Removing a tag is not an easy process, but it is one that is possible, mostly through understanding, validating, and re-accessing. The purpose of fear is not to paralyze from action, but to give an innate category or sense of a situation or choice. Here is a sample scenario an anorexic and therapist might work through, such as a fear of going to parties. (Recall, that in many instances, the fears encapsulating an eating disorder are varied, not all directly involving food.) In this scenario, the anorexic was often told, "That's silly. No reason to fear a group of people." The patient agreed, but since high school she had struggled with fear of parties, no matter how often she tried to ignore and suppress her fear and tell herself that others were right. DBT, however, focuses on accepting emotions as *valid parts* of the reasoning process. For the anorexic, her fear would remain until it was validated and understood.

From promptings from the therapist, the anorexic went through memory recall and found an early memory from a time when she was 11 and went to a party with her parents. She spilled some grape soda on her shirt, and a group of adults laughed at her. Embarrassed, she ran to the bathroom and hid until time to leave, creating a tag that associated parties with fear of embarrassment. The anorexic was relieved to find a reason for her "illogic"; after all, it was a perfectly logical association for an 11-year-old. On discussing the incident with the therapist, who helped her understand and validate her fear, the anorexic then realized that her fear was

grounded in a very old experience, and upon re-accessing it, decided to let it go. As Aristotle would say, she saw all the possible means of persuasion by understanding the emotional logic, and chose to persuade herself otherwise.

Logos and Pathos in Concert

One further piece that needs additional discussion outside of individual treatment of ethos, logos, and pathos is the unique correlation between logos and pathos in DBT. Because DBT focuses on helping patients resolve the tension between logic and emotions, the rhetorical skills taught are not to use logic or emotions in isolation in self-persuasion, but to use them in synthesis. As Linehan described it, "Dialectical strategies stress the creative tensions generated by contradictory emotions and oppositional thought patterns, values, and behavioral strategies, both within the person and in the person's environment" (201). In DBT, the therapist works to cultivate wisdom in the patient through synthesizing knowledge and experience. Emotions and experiences both within the person and in the person's environment are considered key, as is all the logic the patient uses internally and externally. The model described by Linehan is "wise mind" (214). The patient is given the model that there are three minds—reasonable mind, emotional mind, and wise mind. Reasonable mind is the logical, cool side—our logos appeal. Emotional mind is the hot mind processing all the neurons of the moment—the pathos. The goal for a patient, similar to Aristotle's goal for arriving at truth, is to oppose the emotion and reason dialectically to synthesize them into a truth or knowledge. To use Nienkamp's terms, the patient needs to encompass both the skills of *kairos* and *phronesis*—recognizing and judging wisely (Nienkamp 133).

When entering a therapy situation, anorexics typically do not have the rhetorical skills for either logical or emotional dialectic; they tend to leap to extremes one way or another, resulting

in extreme behaviors. Some bury all emotion in logic, refusing to feel, acting based not on what they want, but what "should be." Others bury logic in pain, only reacting addictively in situations, without considering consequences. To find balance, therapists must apply rhetorical skills to persuade patients to see the balance from opposing sides. This includes validating both emotional and logical reasoning (instead of suppressing emotions in favor of logic or burying logic in pain), and teaching patients to use both as tools. By teaching an anorexic to see both sides, the therapist teaches that "reality is a holistic process in a state of constant development and change" (201) when the patient is likely to fall into the trap of privileging either reason or emotion, but not accepting both as valid pieces of the puzzle.

Conclusion

Therapy studies models the human psyche not as a text, but as a series of connections with people and our environment formed through our emotional reactions. As one psychologist described it, "Humans are social animals; we're wired to connect" (Deitz 2). Whether emotional or logical, internal and external rhetorics are intertwined. Therapists maintain that developing the ability to control one's own internal rhetoric and protect against negative external rhetorics is the personal project and moral responsibility of every individual. That is precisely what DBT attempts to do: help individuals understand the influence of external emotions, experiences, and narratives of their own internal self and take control to construct their preferred rhetoric.

Psychology and rhetoric share much history and continue to inform and enrich each other in the present. Psychology, in many ways, is the heritage of rhetoric, since the art of thinking and arriving at truth used to be primarily located in rhetoric before branching into today's fields of psychology and philosophy. Although separate, the fields of thought are useful to examine together. Rhetoricians can find much about audience psychology and understanding from

studying psychology, and psychologists, specifically therapists, can find many useful therapeutic tools in the archives of rhetoric. The theories of internal rhetoric and the dialogical self are very similar and both shed light on the areas of persuasion of self and of others. Crossing the fields of theory together provides even deeper practical implications for present application of these carefully gleaned principles of human understanding and behavior.

DBT is an effective, highly proven therapy technique with a rich rhetorical history of persuasion. It owes much of its current success today from the dialectical tradition of Protagoras and other rhetoricians. As therapists continue studying this newer therapy model, they will hopefully be able to take those tools and build an even more effective future, where truth is found through considering both sides of the dialectic, and by resolving tensions of emotions and logic through synthesis. As Cicero said, "The entire theory of emotions can be summed up in a single point: That they are in our power" (63).

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