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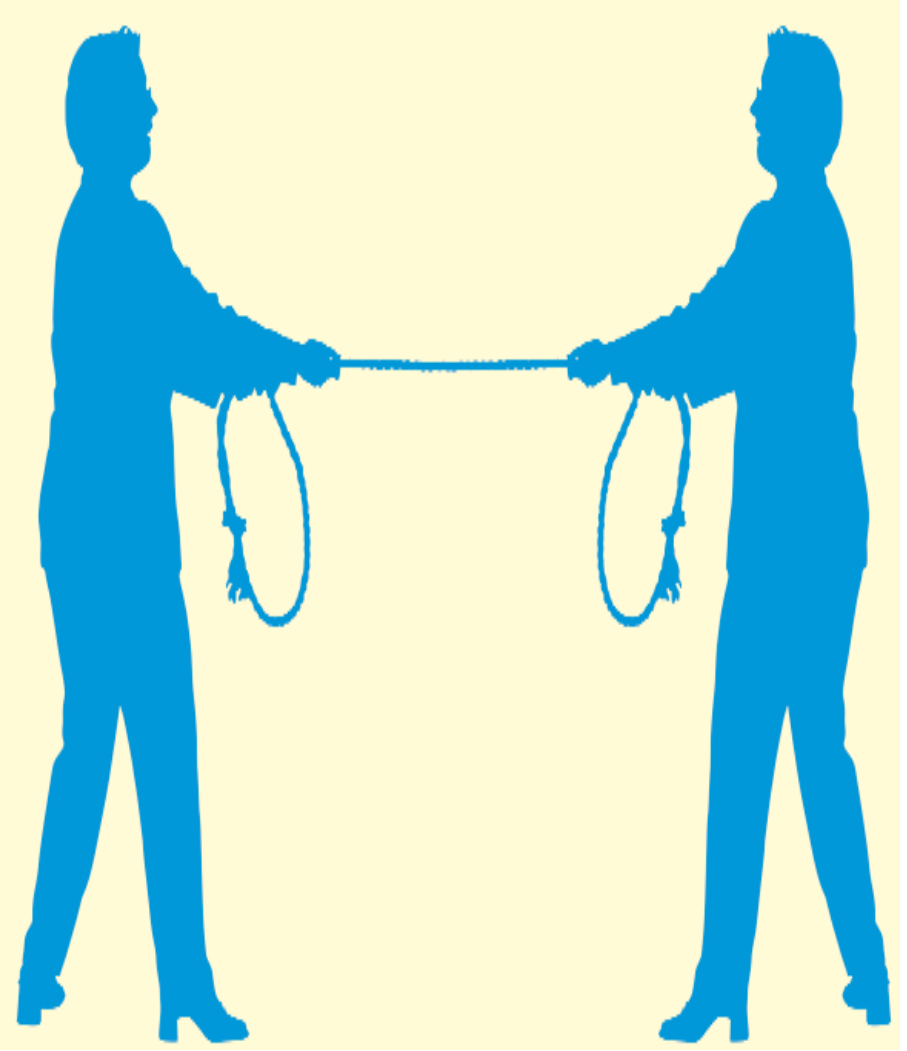
Dialectical Behavior Therapy: *Current Indications and Unique Elements*

ABSTRACT

Dialectical behavior therapy (DBT) is a comprehensive, evidence-based treatment for borderline personality disorder (BPD). The patient populations for which DBT has the most empirical support include parasuicidal women with borderline personality disorder (BPD), but there have been promising findings for patients with BPD and substance use disorders (SUDs), persons who meet criteria for binge-eating disorder, and depressed elderly patients. Although DBT has many similarities with other cognitive-behavioral approaches, several critical and unique elements must be in place for the treatment to constitute DBT. Some of these elements include (a) serving the five functions of treatment, (b) the biosocial theory and focusing on emotions in treatment, (c) a consistent dialectical philosophy, and (d) mindfulness and acceptance-oriented interventions.



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INTRODUCTION

Dialectical behavior therapy (DBT)[1] evolved from Marsha Linehan's efforts to create a treatment for multiproblematic, suicidal women. Linehan combed through the literature on efficacious psychosocial treatments for other disorders, such as anxiety disorders, depression, and other emotion-related difficulties, and assembled a package of evidence-based, cognitive-behavioral interventions that directly targeted suicidal behavior. Initially, these interventions were so focused on changing cognitions and behaviors that many patients felt criticized, misunderstood, and invalidated, and consequently dropped out of treatment altogether.

Through an interplay of science and practice, clinical experiences with multiproblematic, suicidal patients sparked further research and treatment development. Most notably, Linehan weaved into the treatment interventions designed to convey acceptance of the patient and to help the patient accept herself, her emotions, thoughts, the world, and others. As such, DBT came to rest on a foundation of dialectical philosophy, whereby therapists strive to continually balance and synthesize acceptance and change-oriented strategies.

Ultimately, this work culminated in a comprehensive, evidence-based, cognitive-behavioral treatment for borderline personality disorder (BPD). The standard DBT treatment package consists of weekly individual therapy sessions (approximately 1 hour), a weekly group skills training session (approximately 1.5–2.5 hours), and a therapist consultation team meeting (approximately 1–2 hours). At present, eight published, well-controlled, randomized, clinical trials (RCTs) have demonstrated that DBT is an efficacious and specific[2] treatment for BPD and related problems.

This article highlights several key aspects of DBT and is organized around central questions that practitioners may have in deciding whether and how to implement the treatment. In so doing, this article primarily highlights aspects of the theory and practice of DBT that set this treatment apart from other approaches, who the suitable patient populations are, and critical and unique elements of DBT that must be in place for any given patient.

WHEN TO APPLY DBT: USING THE RESEARCH EVIDENCE AS A GUIDE

In deciding whether to use DBT or other treatments for a particular patient, one key deciding factor is the research data on the treatment with patients that are similar in terms of problem areas, diagnoses, or characteristics to the patient in question. Researchers and treatment developers have applied DBT to a variety of patient populations, but the preponderance of RCTs has focused on persons (mainly women) with BPD.[3] The following section includes a brief review of the well-controlled RCTs that have evaluated DBT.

Parasuicidal patients with BPD. For parasuicidal BPD patients, the most consistent finding is that DBT results in superior reductions in parasuicidal behavior compared with control conditions. The first RCT of DBT (*N*=44 parasuicidal women with BPD) found that DBT outperformed a control condition consisting of treatment as it usually is conducted in the community (TAU, or treatment-as-usual) in reducing the frequency and medical severity of parasuicide, inpatient hospitalization days, trait anger, and social functioning.[4] Through the first six months of the 12-month follow-up period, DBT patients demonstrated less parasuicidal behavior and anger and better social adjustment. Findings regarding better social adjustment persisted throughout the final six months of the follow-up period, and DBT patients also had fewer inpatient psychiatric days during this period.

The most recent and largest RCT of DBT (*N*=101) replicated the first study with a more rigorous control condition consisting of treatment by community practitioners designated as experts in treating BPD (treatment-by-community experts, or TBCE). This study found that DBT patients had greater reductions in suicide attempts, psychiatric hospitalization, medical risk of parasuicidal behavior, angry behavior, and emergency room visits, compared with TBCE patients[5] across the 12-month treatment and the 12-month follow-up period.

A couple of studies have examined DBT for women with BPD in community settings, such as a community mental health center and a VA hospital. In a community mental health setting, Turner[6] compared a modified version of DBT that only included individual therapy to a client-centered therapy control condition. Patients in the DBT condition had greater reductions in suicide attempts, deliberate self-harm, inpatient days, suicidal ideation, impulsivity, anger, and global mental health problems. In addition, a study of women veterans with BPD found that DBT patients had greater reductions in suicidal ideation, hopelessness, depression, and anger experienced than did TAU patients.[7] Follow-up data for these two studies are not available.

Women with BPD and substance use disorders. The second patient group for which DBT has demonstrated promising data consists of women with BPD and a substance use disorder (SUD). The first study in this area compared DBT to TAU for women who met criteria for BPD and SUD[8] and found that DBT patients

showed greater reductions in drug use during the 12-month treatment and through the four-month follow up period and had lower drop out rates during treatment. For a second study conducted by Linehan's group, opiate-dependent women with BPD were randomly assigned to two conditions: DBT or a rigorous control condition, called Comprehensive Validation Treatment with 12-step (CVT-12S). In both conditions, participants also received LAAM (levomethadyl acetate hydrochloride), an opiate replacement medication. CVT-12S consisted of a stripped down version of DBT that only involved acceptance-oriented interventions designed to control for time of access to treatment, academic treatment setting, and therapist experience and commitment. Participants in both DBT and CVT-12S showed significant reduction in opiate use during the 12-month treatment, but DBT patients had greater sustained abstinence from opiate use at the 16-month follow-up.[9]

A couple of RCTs conducted outside of the US also have examined DBT for substance abusers with BPD. A recent study conducted at the Centre for Addiction and Mental Health (CAMH) in Canada compared standard DBT to treatment-as-usual (TAU) for women with BPD and a substance use disorder (N=27).[10] DBT patients demonstrated greater reductions in suicidal and parasuicidal behaviors and alcohol use, but not other drug use. A study conducted in the Netherlands[11,12] included BPD patients, 53 percent of whom met criteria for a substance use disorder (SUD). Findings indicated that DBT patients had greater reductions in parasuicidal behavior and impulse-control problem behaviors (including bingeing, gambling, and reckless driving, but not substance abuse), compared with TAU patients. DBT patients continued to demonstrate less parasuicidal behavior, impulsive behaviors, and alcohol use throughout the six-month follow-up period.

Other clinical populations and problems. Additionally, some research has examined DBT-oriented treatments for other clinical problems, including eating disorders and depression in elderly patients. Telch and colleagues[13] compared a 20-week DBT-based skills training group to a wait list control condition for women with binge-eating disorder and found that DBT patients had greater improvements in bingeing, body image, eating concerns, and anger.

PEOPLE WHO MAY BENEFIT FROM DBT

- Parasuicidal patients with BPD
- Female patients with BPD and SUD
- Patients with eating disorders
- Elderly patients with depression and personality disorders

DBT: dialectical behavior therapy
BPD: borderline personality disorder
SUD: substance use disorder

Although 86 percent of DBT participants had stopped bingeing by the end of treatment, this number declined to 56 percent during the six-month follow-up period. A second study compared a modified version of individual DBT that included skills training to a wait list condition. DBT patients had greater reductions in bingeing and purging.[14] No follow-up data are currently available for this latter study.

In a study of depressed elderly patients who met criteria for a personality disorder,[15] investigators compared an adapted version of DBT plus antidepressant medications to medications only. Findings indicated that a larger proportion of DBT patients were in remission from depression at post-treatment and at the six-month follow-up period.

Summary. In summary, the patients for whom DBT has the strongest and most consistent empirical support include parasuicidal women with BPD. There also are some promising data on DBT for women with BPD who struggle with substance use problems. Preliminary data suggest that DBT may have promise in reducing binge-eating and other eating-disordered behaviors. On the one hand, the most conservative clinical choice would be to limit DBT to women with BPD. On the other hand, DBT is a comprehensive treatment that includes elements of several evidence-based, cognitive-behavioral interventions for other clinical problems. As such, DBT often is applied in clinical settings to multiproblematic patients in general, including those patients who have comorbid Axis I and II disorders, and/or who are suicidal or self-injurious; however, caution is important in applying a treatment beyond the patients with whom it has been evaluated in the research.

CRITICAL AND UNIQUE ELEMENTS OF DBT

The following section involves a discussion of some of the critical and unique elements of DBT. DBT is a comprehensive treatment that includes many aspects of other cognitive-behavioral approaches, such as behavior therapy (i.e., exposure, contingency management, problem solving, and stimulus control), cognitive restructuring, and other such interventions. As many of these interventions are very similar to those found in other treatments, the emphasis here is on those essential aspects of treatment that are relatively specific and unique to DBT, including (a) five functions of treatment, (b) biosocial theory and focusing on emotions in treatment, (c) dialectical philosophy, and (d) acceptance and mindfulness.

Five functions of treatment. DBT is a comprehensive program

of treatment consisting of individual therapy, group therapy, and a therapist consultation team. In this way, DBT is a program of treatment, rather than a single treatment method conducted by a practitioner in isolation. Often, clinicians are interested in applying DBT but find the prospect of implementing such a comprehensive treatment to be daunting. In this case, it is important to remember that the most critical element of any DBT program has to do with whether it addresses five key functions of treatment. Although the standard package of DBT has the most empirical support, different settings and circumstances may necessitate innovative and creative applications of DBT. In all cases, however, it is critical that any adaptation of DBT fulfills the following five functions:

Function #1: Enhancing capabilities. Within DBT, the assumption is that patients with BPD either lack or need to improve several important life skills, including those that involve (a) regulating emotions (emotion regulation skills), (b) paying attention to the experience of the present moment and regulating attention (mindfulness skills), (c) effectively navigating interpersonal situations (interpersonal effectiveness), and (d) tolerating distress and surviving crises without making situations worse (distress tolerance skills).[15] As such, improving skills constitutes one of the key functions of DBT. This function usually is accomplished through a weekly skills group session, consisting of approximately 4 to 10 individuals and involving didactics, active practice, discussion of new skills, as well as homework assignments to help patients practice skills between sessions.

Function #2: Generalizing capabilities. If the skills learned in therapy sessions do not transfer to patients' daily lives, then it would be difficult to say that therapy was successful. As a result, a second critical function of DBT involves generalizing treatment gains to the patient's natural environment. This function is accomplished in skills training by providing homework assignments to practice skills and troubleshooting regarding how to improve upon skills practice. In individual therapy sessions, therapists help patients apply new skills in their daily lives and often have patients practice or apply skillful behaviors in session. In addition, the therapist is available by phone between sessions to help the patient apply skills when they are most needed (e.g., in a crisis).

CRITICAL ELEMENTS OF DBT

- Five functions of treatment
  - Enhancing capabilities
  - Generalizing capabilities
  - Improving motivation and reducing dysfunctional behaviors
  - Enhancing and maintaining therapist capabilities and motivation
  - Structuring the environment.
- Biosocial therapy and focusing on emotions in treatment
- Dialectical philosophy
- Acceptance and mindfulness

Function #3: Improving motivation and reducing dysfunctional behaviors. A third function of DBT involves improving patients' motivation to change and reducing behaviors inconsistent with a life worth living. This function primarily is accomplished in individual therapy. Each week, the therapist has the patient complete a self-monitoring form (called a "diary card") on which he or she tracks various treatment targets (e.g., self-harm, suicide attempts, emotional misery). The therapist uses this diary card to prioritize session time, giving behaviors that threaten the patient's life (e.g., suicidal or self-injurious behaviors) highest priority, followed by behaviors that interfere with therapy (e.g., absence, lateness, noncollaborative behavior), and behaviors that interfere with the patient's quality of life (e.g., severe problems in living, unemployment, or severe problems related to Axis I disorders).

After prioritizing the behavioral targets for a given session, the therapist helps the patient figure out what led up to the behavior(s) in question and the consequences that may be reinforcing or maintaining the behavior(s). The therapist also helps the patient find ways to apply skillful, effective behavior, solve problems in life, or regulate emotions. In terms of enhancing motivation, the therapist actively works to get the patient to commit to behavior change, using a variety of "commitment" strategies.[1]

Function #4: Enhancing and maintaining therapist capabilities and motivation. Another important function of DBT involves maintaining the motivation and skills of the therapists who treat patients with BPD. Although helping multiproblematic BPD patients can be stimulating and rewarding, these patients also engage in a potent mix of behaviors that can tax the coping resources, competencies, and resolve of their treatment providers (i.e., suicide attempts, repeated suicidal crises, behaviors that interfere with therapy). As a result, one essential ingredient of an effective treatment for BPD patients is a system of providing support, validation, continued training and skill-building, feedback, and encouragement to therapists.

To address this function, standard DBT includes a therapist consultation-team meeting, for which DBT therapists meet once per week for approximately 1 to 2 hours. The team helps therapists problem-solve ways to implement effective treatment in the face of specific clinical challenges (e.g., a

suicidal patient, a patient who misses sessions). In addition, the team encourages therapists to maintain a compassionate, nonjudgmental orientation toward their patients; monitors and helps reduce therapist burnout; provides support and encouragement; and sometimes employs structured training/didactics on specific therapeutic skills.

Function #5: Structuring the environment. A fourth important function of DBT involves structuring the environment in a manner that reinforces effective behavior/progress and does not reinforce maladaptive or problematic behavior. Often, this involves structuring the treatment in a manner that most effectively promotes progress. Typically, in DBT, the individual therapist is the primary therapist and is "in charge" of the treatment team. He or she makes sure that all of the elements of effective treatment are in place, and that all of these functions are met.

Structuring the environment may also involve helping patients find ways to modify their environments. For instance, drug-using patients may need to learn how to modify or avoid social circles that promote drug use; patients who self-harm sometimes need to learn how to make sure that their partners or significant others do not reinforce self-harm (i.e., by being overly soothing, warm, or supportive). In DBT, the therapist normally has the patient modify his or her environment, but at times, may take an active role in changing patients' environments for them (e.g., if the environment is overwhelming or too powerful for the patient to have a reasonable degree of influence).[1]

The biosocial theory and emphasizing emotions in treatment. In addition to serving the five functions mentioned previously, DBT is anchored in a theory of BPD that prompts clinicians to focus on emotions and emotion regulation in treatment. According to the biosocial theory of BPD, persons with BPD are born with a biologically hard-wired temperament or disposition toward emotion vulnerability.[1] Emotion vulnerability consists of a relatively low threshold for responding to emotional stimuli, intense emotional responses, and difficulty returning to a baseline level of emotional arousal. Without very skillful and effective parenting or child-rearing, the child has difficulty learning how to cope with such intense emotional reactions.

The central environmental factor consists of a rearing environment that invalidates the child's emotional responses by ignoring, dismissing, or punishing them, or by oversimplifying the ease of coping/problem solving. The invalidating environment transacts with the child's disposition toward emotion vulnerability, thus increasing the risk of developing BPD. As a result, the child is left bereft of the skills needed to regulate emotions, often is afraid of his or her emotions (i.e., "emotion phobic"),[1] and may resort to quickly executable, self-destructive ways to cope with emotions (e.g., deliberate self-harm).[17]

Based on the conceptualization of BPD as a disorder of emotion dysregulation, DBT is an emotion-focused treatment. One of the primary goals of DBT is to improve patients' quality of life by reducing "…ineffective action tendencies associated with dysregulated emotions."[18,19] As such, DBT includes many behavioral skills that specifically aim to teach patients how to recognize, understand, label, and regulate their emotions (i.e., the emotion regulation skills). Inside DBT sessions, the therapist attends to the patient's emotional reactions, particularly when they interfere with progress, and many of the interventions most commonly used in DBT involve helping patients to regulate their emotions.

Along these lines, in applying DBT to patients with BPD, therapists must have the skills and knowledge needed to work with emotions in treatment. In particular, therapists must be knowledgeable about research on emotions and emotion regulation.[20] In addition, several essential skills for therapists involve (a) noticing emotions and their roles in problematic behavior, (b) noticing

IN SUGGESTING SOLUTIONS OR SKILLS, [the therapist] often suggests both acceptance-based (e.g., radical acceptance, tolerating distress, being mindful of current emotional or other experiences) and change-based (e.g., solving the problem, changing behaviors, changing environments and reinforcement

emotional reactions of the patient through changes in facial expression, body language, voice-tone, and other such indicators of emotional states, (c) helping patients to accurately label emotional states, (d) validating emotional responses that are valid or that fit the facts of the situation, (d) discriminating when particular skills are likely to be useful in helping patients regulate (or accept) their emotions, and (e) teaching patients how to apply emotion regulation strategies when they are emotionally overwhelmed.

Dialectical philosophy in DBT. Dialectical philosophy is the fuel that powers much of what is unique about DBT in comparison to other cognitive-behavioral treatments. Dialectical philosophy most commonly is associated with the thinking of Marx or Hegel but has existed in one form or another for thousands of years.[21,22] Within a dialectical framework, reality consists of opposing, polar forces that are in tension. For instance, the push to apply change-oriented treatment strategies creates tension by increasing patient's desire to be accepted rather than changed. Dialectical philosophy also poses that each opposing force is incomplete on its own, and that these forces continually are balanced and synthesized. This also is the case in DBT. On the one hand, focusing completely on change-oriented efforts was an incomplete strategy, as it lacked the essential ingredient of acceptance. On the other hand, focusing completely on acceptance of the patient also may be incomplete and ineffective, as multiproblematic, suicidal patients require extensive changes in order to create lives that are worth living.

Dialectical thinking influences many aspects of the therapist's approach and style. For instance, the therapist continually seeks to balance and synthesize acceptance and change-oriented strategies in the most effective possible manner. Within each session, the therapist works to provide a balance of acceptance and validation with problem solving/behavior change strategies. In suggesting solutions or skills, he or she often suggests both acceptance-based (e.g., radical acceptance, tolerating distress, being mindful of current emotional or other experiences) and change-based (e.g., solving the problem, changing behaviors, changing environments and reinforcement contingencies, changing cognitions) solutions. When the therapist and patient lock horns on particular issues, dialectical thinking allows the therapist to let go of the desire to be "right" and focus on ways to synthesize his or her perspective or opinion with that of the patient (based on the idea that each position is likely to be incomplete on its own). Finally, in DBT, there is an emphasis on movement, speed, and flow within therapy sessions. Therapists use a variety of therapy strategies and also vary their style and intensity from lively and energetic, to slow and methodical, and from reciprocal and validating to irreverent and off-beat. In addition, therapists modify their approach based on what is working/not working in the moment.

Acceptance and mindfulness in DBT. In DBT, several interventions and skills are geared toward conveying acceptance of the patient and helping the patient accept him or herself, others, and the world. One such intervention is mindfulness. In DBT, mindfulness skills help patients attend to what is happening in the present. Some of the mindfulness skills involve attending to and nonjudgmentally observing the current experience, describing the facts of the current experience or situation, and fully participating in the activity/experience of the present, while attending to one thing at a time ("one-mindfully")[16] and focusing on effective, skillful behavior. Therapists teach patients mindfulness skills in skills training, encourage mindfulness in individual therapy, and often practice mindfulness themselves.

Taught in the distress tolerance module of skills training, another acceptance intervention in DBT is called radical acceptance, which essentially involves accepting the experience of the present moment for what it is, without struggling to change it or willfully resisting it. Finally, another acceptance intervention in DBT involves conveying acceptance of the patient through validation, which involves verifying or acknowledging the validity or truth in the patient's experience, emotional reactions, thoughts, or opinions.[1] An essential skill for therapists in DBT (as discussed previously) involves knowing when and how to apply the most effective acceptance-oriented strategies, given the characteristics and difficulties of the patient and the context of the therapy session.

ESSENTIAL SKILLS FOR THERAPISTS WHO APPLY DBT

- Noticing emotions and their roles in problematic behavior
- Noticing emotional reactions of the patient, through changes in facial expression, body language, voice-tone, and other such indicators of emotional states
- Helping patients to accurately label emotional states
- Validating emotional responses that fit the facts of the situation
- Discriminating when particular skills are likely to be useful in helping patients regulate (or accept) their emotions
- Teaching patients how to apply emotion regulation strategies when they are emotionally overwhelmed

SUMMARY

In summary, DBT is a comprehensive, cognitive-

behavioral treatment originally designed to help suicidal women. The patient populations for which DBT has the most empirical support include parasuicidal women with BPD, but there have been promising findings for patients with BPD and SUDs, persons who meet criteria for binge-eating disorder, and depressed elderly patients with personality disorders. Although DBT has many similarities with other cognitive-behavioral approaches, several critical and unique elements must be in place for the treatment to constitute DBT. Some of these elements include (a) serving the five functions of treatment, (b) the biosocial theory and focusing on emotions in treatment, (c) a consistent dialectical philosophy, and (d) mindfulness and acceptance-oriented interventions. Persons interested in learning more about DBT might begin with Linehan's[1] comprehensive treatment manual. In addition, Behavioral Tech, LLC (www.behavioraltech.com) offers periodic workshops on DBT. Currently, there is no certification in DBT as a specialty or as a special proficiency.

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REFERENCES

1. Linehan MM. *Cognitive-Behavioral Treatment of Borderline Personality Disorder.* New York, NY: Guilford Press, 1993.
2. Chambless DL, Hollon SD. Defining empirically supported therapies. *J Consult Clin Psychol* 1998;66:7–18.
3. Robins CJ, Chapman AL. Dialectical behavior therapy: Current status, recent developments, and future directions. *J Personal Disord* 2004;18:73–9.
4. Linehan MM, Armstrong HE, Suarez A, et al. Cognitive-behavioral treatment of chronically suicidal borderline patients. *Arch Gen Psychiatry* 1991;48:1060–4.
5. Linehan MM, Comtois KA, Murray AM, et al. Suicidal and behavioral outcomes from a one-year randomized trial and one-year follow up of dialectical behavior therapy for borderline personality disorder. *Arch Gen Psychiatry* 2006;63:757–66.
6. Turner RM. Naturalistic evaluation of dialectical behavior therapy-oriented treatment for borderline personality disorder. *Cognit Behav Pract* 2000;7:413–9.
7. Koons, C, Robins, CJ, Tweed, JL, et al. Efficacy of dialectical behavior therapy in women veterans with borderline personality disorder. *Behav Ther* 2001;32:371–90.
8. Linehan MM, Schmidt HI, Dimeff LA, et al. Dialectical behavior therapy for patients with borderline personality disorder and drug-dependence. *Am J Addict* 1999;8:279–92.
9. Linehan MM, Dimeff LA, Reynolds SK, et al. Dialectical behavior therapy versus comprehensive validation therapy plus 12-step for the treatment of opioid dependent women meeting criteria for borderline personality disorder. *Drug Alcohol Depend* 2002;67:13–26.
10. McMain S. Dialectical behaviour therapy for individuals with borderline personality disorder and substance abuse: A randomized controlled pilot study. Presentation. New Orleans, LA: Association for the Advancement of Behavior Therapy, 2004.
11. Verheul R, van den Bosch LMC, Koeter MWJ. Dialectical behavior therapy for women with borderline personality disorder. *Br J Psychiatry* 2003;182:135–40.
12. van den Bosch LMC, Koeter M, Stijnen T, et al. Sustained efficacy of dialectical behavior therapy for borderline personality disorder. *Behav Res Therapy* 2005;43:1231–41.
13. Telch CF, Agras WS, Linehan MM. Dialectical behavior therapy for binge eating disorder. *J Consult Clin Psychol* 2001;69:1061–5.
14. Safer DL, Telch CF, Agras WS. Dialectical behavior therapy for bulimia nervosa. *Am J Psychiatry* 2001;158:632–4.
15. Lynch TR, Morse JQ, Mendelson T, et al. Dialectical behavior therapy for depressed older adults: A randomized pilot study. *Am J Geriatr Psychiatry* 2003;11:33–45.
16. Linehan MM. *Skills Training Manual for Treating Borderline Personality Disorder.* New York, NY: Guilford Press, 1993.
17. Chapman AL, Gratz KL, Brown M. Solving the puzzle of deliberate self-injury: The experiential avoidance model. *Behav Res Ther* 2006;44:371–94.
18. Chapman AL, Linehan MM. Dialectical behavior therapy for borderline personality disorder. In: Zanarini M (ed). *Borderline Personality Disorder.* New York, NY: Taylor & Francis, 2005:211–42.
19. Lynch TR, Chapman AL, Rosenthal MZ, et al. Mechanisms of change in dialectical behavior therapy: Theoretical and empirical observations. *J Clin Psychol* 2006;62:459–80.
20. Gross JJ. The emerging field of emotion regulation: An integrative review. *Rev Gen Psychol* 1998;2:271–99.
21. Bopp MJ, Weeks GR. Dialectical metatheory in family therapy. *Fam Process* 1984;23:49–61.
22. Kaminstein DS. Toward a dialectical metatheory for psychotherapy. *J Contemp Psychother* 1987;17:87–101.