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Emerging Approaches to Counseling Intervention: Dialectical Behavior Therapy

Andrada D. Neacsiu, Erin F. Ward-Ciesielski, and Marsha M. Linehan

Abstract
Dialectical Behavior Therapy (DBT) is a comprehensive, multimodal cognitive-behavioral treatment originally developed for individuals who met criteria for borderline personality disorder (BPD) who displayed suicidal tendencies. DBT is based on behavioral theory but also includes principles of acceptance, mindfulness, and validation. Since its development, DBT has been adapted to various populations and has been successfully used in a wide array of settings. This article presents the approaches used in DBT with a particular emphasis on (a) the philosophy and assumptions on which the treatment is based, (b) the major theoretical constructs and the DBT conceptualization of the client, (c) the intervention and specific techniques used, (d) research supporting the theory and treatment, and (e) the integration of diversity, culture, and social justice.

Keywords
professional issues, psychotherapy, training

Dialectical Behavior Therapy (DBT) is a comprehensive cognitive behavioral treatment developed in the early 1980s (Linehan, 1987, 1989) for the comorbid and difficult-to-treat client. The treatment was originally intended for suicidal
individuals, and it emerged when standard cognitive-behavioral therapy (CBT) failed with this population (Linehan, 1993a). The emphasis on change, typical of CBT strategies at the time, was often perceived as invalidating by suicidal clients who responded by withdrawing, attacking the counselor, or quitting treatment. In addition, the competing demands of decreasing suicidality, attending to chaotic behaviors, teaching new behavioral skills, and managing in-session distress made therapy sessions with this client population very difficult. To address these treatment obstacles, DBT provides a comprehensive, multimodal treatment for suicidal individuals who meet criteria for borderline personality disorder (BPD) that is based on behavioral theory but also includes principles of acceptance, mindfulness, and validation (Dimeff & Linehan, 2001; Robins, Schmidt, & Linehan, 2004).

Since its development, DBT has been applied with highly suicidal individuals meeting criteria for BPD (Linehan et al., 2006; Turner, 2000) and has been adapted for adults meeting criteria for both BPD and substance dependence (Dimeff, Comtois, & Linehan, 1998), suicidal adolescents with BPD features (Rathus & Miller, 2002), suicidal elderly individuals who meet criteria for major depressive disorder (Lynch et al., 2007), adults with eating disorders (Safer, Telch, & Agras, 2001), oppositional children (Nelson-Gray et al., 2006), victims of domestic abuse (Iverson, Shenk, & Fruzzetti, 2009), stalking offenders (Rosenfeld et al., 2007), families of highly suicidal individuals (Rajalin, Wickholm-Pethrus, Hursti, & Jokinen, 2009), and difficult-to-manage correctional populations (Shelton, Sampl, Kesten, Zhang, & Trestman, 2009). The large number of studies conducted in community settings suggests that DBT is quite transportable across various clinical environments (e.g., Comtois, Elwood, Holdcraft, Simpson, & Smith, 2007; Koons et al., 2001; Verheul et al., 2003).

Philosophy and Assumptions

DBT is based on three philosophical pillars: dialectics, Zen, and behavioral science. The treatment was initially developed from a wholly behavioral science approach based on learning theory, social and cognitive psychology, and other psychological research commonly supporting behavior therapy interventions. The difficulties engaging clients in the therapeutic process with such an approach were readily apparent, leading to a search for acceptance-based treatment strategies to balance the traditional behavioral emphasis on change (Dimeff & Linehan, 2001).

To balance the change needed for the BPD individual’s life to improve, DBT drew acceptance principles from the Zen philosophy. Zen followers are
encouraged to let go of attachments to what they think reality should be like and find the middle path through means of acceptance, self-validation, and tolerance. In this philosophy, each moment is complete and the world is perfect as it is. The practice of acceptance, as seen from the Zen perspective, emphasizes focusing on the current moment and seeing and accepting reality as it is, without judgment (Robins et al., 2004).

Zen principles were added to DBT by incorporating mindfulness practice. Mindfulness is defined as intentionally living with awareness in the present moment, without judging or rejecting the moment and without attachment to the moment (Linehan, 1993b). To achieve this experience, mindfulness practices—aimed at facilitating the experience of the present moment—were condensed into a form that counselors could teach and clients could understand and use. Such practices include the nonjudgmental observing and/or describing of objects, physical sensations, and emotions and participating fully in experiencing a connection with the universe (Linehan, 1993b). It is important to highlight that mindfulness is at the core of DBT. Even so, mindfulness in DBT is a practice rather than a philosophy. Clients and counselors alike practice it to gain better control over their attention so that, in moments of need, attentional control can be easily gained and effective behavior can be more easily attained.

To put these two opposing approaches together (i.e., acceptance and change) a dialectical philosophy emphasizing the synthesis of opposites was adopted. With severe, multiproblem clients who frequently attempt suicide, self-injure, or use drugs, the clinician is compelled to push for some kind of behavioral change. At the same time, this essential movement toward change generates the need to convey acceptance and validation of the client. Dialectics provided the context for a synthesis of change with acceptance. From a dialectical point of view, the push for change can happen only in the context of acceptance and validation (Koerner & Linehan, 1992).

The dialectical worldview is based on three overarching principles (Linehan, 1993a). First, dialectical philosophy is holistic. No event in the universe can be understood without reference to the whole and to the transactions of events with each other. Thus, both the context of an individual’s behavior and the wider context of his or her environment are critical for understanding each individual. From this perspective, identity is both relational and individual. This principle is applied in DBT by constantly searching for what is left out (Robins et al., 2004).

Second, dialectical philosophy encapsulates opposites. Much like arguments in a debate, each interpretation of reality (the “thesis”) always has a polar opposite (the “antithesis”). In dialectics such tension is solved through
an integration of the two poles, the synthesis. Once a synthesis is reached, the system evolves and change occurs. One example of how this is applied in DBT is the concept of wise mind, which is seen as the synthesis between emotion mind (i.e., mood dependency; the thesis) and rational mind (the antithesis; Linehan, 1993a). For example, DBT clients often report how in the midst of a crisis they find themselves seeing what is happening from the prisms of their emotion. If angry, a client may interpret what other people do as an attack, may view the whole world as having turned against him or her, and may become hopeless and think about suicide as a way out. This is emotion mind thinking. At the same time, clients report perceiving how they are exaggerating the situation, how other people would not get so angry, and how it would be better if they just “got out of it.” This is rational thinking. With few skills to integrate the emotion and the reason, clients vacillate from one extreme to the other, struggling with the tension between these opposites. One way to integrate the opposites and reach wise mind is to accept the emotional arousal and the difficulty of solving the problem in this state while, at the same time, accepting the need to problem solve. A synthesis would be to find a simple solution that would help the client get through the intense emotions (such as distracting or self-soothing) and return to problem solving once the emotional arousal has decreased. This is wise mind thinking.

Third, a dialectical philosophy leads to continuous movement. Dialectics in DBT is often explained using a teeter-totter analogy, with the client at one end and the therapist at the other. The task of the therapist is to maintain the balance between himself or herself and the client in such a way that both move toward the middle point instead of moving toward the extremes. Sometimes the therapist has to move quickly from one side to the other to maintain balance. Similar movement is required when balancing acceptance and change (Dimeff & Linehan, 2001).

This principle is useful with rigid mind thinking. The counselor does not give the client a chance to become rigid on one side of the dialectic. For example, to shift quickly between acceptance and change, the counselor may say,

I agree your life is not where you want it to be [acceptance]. So we should work on getting it there. How can you start looking for a job [change]? I know right now it seems like an overwhelming task [acceptance], but what would be one step to take in that direction [change]? Do you have a résumé [change]?

Alternating validation and problem solving, the counselor does not allow the patient to fall into the hopelessness of his or her situation, nor into underestimating the difficulty of finding a job.
Table 1. Dialectical Behavior Therapy (DBT) Assumptions

Assumptions about clients
1. Clients are doing the best they can
2. Clients want to improve
3. Clients must learn new behaviors in all relevant contexts
4. Clients cannot fail in DBT
5. Clients may not have caused all of their problems, but they need to solve them anyways\textsuperscript{a}
6. Clients need to do better, try harder, and/or be more motivated to change\textsuperscript{b}
7. The lives of suicidal borderline individuals are unbearable the way they are lived\textsuperscript{b}

Assumptions about counselors and therapy
1. The most caring thing a counselor can do is help clients change in ways that bring them closer to their own ultimate goals
2. Clarity, precision, and compassion are of the utmost importance in the conduct of DBT
3. The therapeutic relationship is a real relationship between equals
4. Principles of behavior are universal, affecting counselors no less than clients
5. Counselors treating borderline clients need support
6. DBT counselors can fail
7. DBT can fail even when counselors do not

\textsuperscript{a}Does not apply to adolescent clients.
\textsuperscript{b}Applies to BPD clients, not necessarily to all clients (Linehan, 1993a).

In addition to the overarching assumptions derived from the philosophy of the treatment, practical issues have led to additional basic assumptions about clients, therapists, and therapy that were integrated into the DBT treatment model (see Table 1). The assumptions have been replicated from Linehan’s (1993a) original treatment manual and from the adapted manual for suicidal adolescents (Miller, Rathus, & Linehan, 2007). For example, by adopting the assumption that clients want to improve, both treatment providers and clients are compelled to search for more solvable problems. A lack of motivation becomes the absence of appropriate reinforcers in the client’s environment. As a result, one purpose of therapy is to reduce interfering factors and set appropriate reinforcers so that the client can do better, try harder, and be more motivated to change.

Another example is the assumption that clients must learn new behaviors in all relevant contexts. Because many behaviors are mood dependent, clients must learn to change their behavior under extreme moods, not only when they are in emotional balance. This is an important treatment guideline because it underscores the potential deleterious effects of hospitalization. In a crisis, the
The principal goal of the counselor is not to save the client but to help the client learn how to manage that crisis better. DBT counselors are reluctant to hospitalize because committing a client takes the individual out the environment where he or she needs to learn new skills (i.e., managing the crisis) and may provide inappropriate reinforcement for dysfunctional responses to crisis situations.

**Major Theoretical Constructs and View of the Person**

**The Biosocial Theory**

DBT is based on a biosocial model that posits the transaction between an emotionally vulnerable child and an invalidating environment as the principle etiological factor in BPD (Linehan, 1993a; Putnam & Silk, 2005). The key vulnerability is a biological predisposition that manifests initially as impulsivity and leads to heightened emotional sensitivity, emotional reactivity, and slow return to an emotional baseline (Crowell, Beauchaine, & Linehan, 2009). The emotionally vulnerable child needs a validating environment—where coaching in emotion management is provided—to thrive. However, a central characteristic of the histories of many BPD individuals is an environment with insufficient emotional validation and emotional coaching. Such environments range from the consistently invalidating environments found in the lives of many BPD individuals who have histories of childhood trauma, neglect, or unrealistic demands, to the highly stressed environments where caregivers—although intending to provide sufficient nurturing—provide ineffective or insufficient validation and coaching (Fruzzetti, Shenk, & Hoffman, 2005).

An invalidating environment punishes emotional expression, intermittently reinforces extreme displays, or insufficiently authenticates or altogether denies the private experience the child communicates (e.g., “you’re not sad, you’re hungry”). Consequently, the child does not learn how to understand, label, regulate, or tolerate emotional responses and instead learns to oscillate between emotional inhibition and extreme emotional lability. The child also fails to learn how to solve the problems contributing to these emotional reactions and how to manage the consequences of emotional experiences (Crowell et al., 2009). Furthermore, rumination is hypothesized to contribute to maintaining this connection between sensitivity and emotion dysregulation (Selby & Joiner, 2009).

Existing evidence supports this biosocial theory (Putnam & Silk, 2005). When compared to controls, individuals who meet criteria for BPD have more frequent and more acute negative emotions (Dougherty, Bjork, Huckabee,
Moeller, & Swann, 1999; Ebner-Priemer et al., 2005; Levine, Marziali, & Hood, 1997; Stein, 1996) and a tendency to recall negative events more easily than positive events (Ebner-Priemer et al., 2006). In addition, when compared to depressed clients, BPD clients show marked affect dysregulation (Conklin, Bradley, & Westen, 2006; Yen, Zlotnick, & Costello, 2002). BPD individuals also appear to have a heightened sensitivity to fear when compared with childhood sexual abuse victims and controls (Wagner & Linehan, 1999). Furthermore, when compared to clients with other personality disorders, BPD clients appear to be less willing to experience distress to pursue goal-directed behavior (Gratz, Rosenthal, Tull, Lejuez, & Gunderson, 2006). Finally, family involvement and increased care lead to better clinical outcomes in BPD patients (Hooley & Hoffman, 1999).

**Emotional Dysregulation**

Based on the biosocial model, theorists proposed emotion dysregulation to be a core feature of the borderline phenotype (Conklin & Westen, 2005; Linehan, 1993a; Linehan, Bohus, & Lynch, 2007; Livesley, Jang, & Vernon, 1998; Skodol et al., 2002). In DBT, emotions are viewed as complex, involuntary, patterned full-system responses to internal and external stimuli. These responses can be seen as having five subsystems that can be targeted by emotion regulation processes. In a very crude simplification for illustrative purposes, an emotion is (a) initially determined by an emotional vulnerability to cues, (b) has as functional units internal and external events that serve as triggers, (c) adds in response tendencies (physiological, cognitive, and experiential tendencies and urges), (d) culminates with nonverbal and verbal expressive responses and actions, and (e) ends with after effects of the initial emotional “firing,” including secondary emotions. These subcomponents are not discrete. Instead, they overlap, mingle, and interact to form the unique pattern of an emotion (Linehan et al., 2007).

In DBT, emotion dysregulation is understood as the inability to alter or control emotional cues, experiences, actions, verbal responses, and nonverbal expressions under average conditions. Characteristics of this dysfunction include excessive negative affect, difficulty controlling physiological arousal, trouble distracting from emotional stimuli, irrational thoughts and faulty appraisal, lack of control over impulsive emotional behaviors, difficulties pursuing non-mood-dependent goals, and a tendency to dissociate under very high stress (Linehan et al., 2007; Rosenthal et al., 2008). Although the theory was initially developed for individuals with a BPD diagnosis, emotion dysregulation is a core feature of many other emotional disorders such as anxiety...
and depression (Kring & Werner, 2004). Therefore, similar principles apply in understanding and working with clients displaying these symptoms.

Another critical theoretical underpinning of DBT is that self-inflicted injuries (including suicide attempts), as well as most other dysfunctional behaviors, are maladaptive attempts at solving problems in living (M. Brown, Comtois, & Linehan, 2002; Schotte & Clum, 1987; Shneidman, 1985). Suicidal individuals are often overwhelmed and in crisis. As a result, they use maladaptive behaviors to respond to this chronic state of crisis, either as an escape mechanism (Chapman, Gratz, & Brown, 2006) or as a way to communicate the discrepancy between capacity and demands facing the individual. For the “apparently competent” person, suicidal behavior is sometimes the only means of communicating to others that he or she really cannot cope and needs help (Koerner & Linehan, 1997; for a more detailed discussion of apparent competence, see the Secondary Targets section below).

**Case Formulation in DBT for BPD**

As with all aspects of the treatment, DBT takes an approach to case formulation that is driven by theory. Koerner and Linehan (1997) describe five critical aspects of DBT case formulation: four stages of treatment that guide the relevant targets of treatment, the biosocial theory of BPD, learning principles used in behavior therapy, the dialectical nature of behavioral patterns in BPD, and a dialectical orientation to change. The majority of these constructs within DBT have already been described elsewhere. What follows is a brief discussion of two other constructs: the stages of treatment and the dialectical nature of behavioral patterns in BPD, also known as secondary targets.

**Four stages of treatment.** Treatment in Stage I focuses on the reduction of out-of-control behaviors that fall into three categories and are ranked in terms of importance as follows: (a) life-threatening behaviors, (b) therapy-interfering behaviors, (c) severe quality-of-life-interfering behaviors. Once a client has achieved reasonable control of severely dysfunctional actions, he or she can move to the next stage of treatment. Therapy in Stage II shifts its focus to increase a client’s ability to experience emotions without also experiencing trauma (Koerner & Linehan, 1992).

The goal of treatment in Stage III is to facilitate the synthesis of what has been learned in previous stages while also increasing the client’s self-respect and sense of connection with the world and decreasing residual problems that interfere with the achievement of personal goals. Finally, in Stage IV, therapy focuses on resolving the client’s residual feelings of incompleteness, which may be present even after problems in living and other previous targets are resolved. Clients may come into treatment at any stage and can move backward
and forward through different stages throughout treatment (Koerner & Linehan, 1997).

**Secondary targets.** When working with BPD clients, a number of secondary targets are important to consider; otherwise, these issues may impede treatment progress. Linehan (1993a) has organized these into three dimensions, each consisting of two poles that may be seen as opposite: emotion vulnerability and inhibited grieving, self-invalidation and active passivity, and unrelenting crises and apparent competence. Although these are conceptualized behavioral patterns of BPD clients, they are presented as secondary targets in DBT because they can impede progress on primary targets. Take, for example, a situation in which the counselor and client conduct an assessment of dysfunctional behavior and discover that the client’s self-invalidation precedes self-injury. The self-invalidation then becomes a secondary target of treatment.

BPD clients characterized with high emotional vulnerability display a pattern of (a) marked difficulty in regulating negative emotions, (b) high emotional intensity, (c) slow return to baseline, and (d) a lack of awareness of this vulnerability. Self-invalidating BPD individuals either fail to recognize their own responses, thoughts, beliefs, and behaviors or recognize but then invalidate them; they have standards that are too high or unreasonable and experience intense shame and self-hate. Finally, the dimension of unrelenting crisis patterns refers to frequent and stressful negative environmental events, disruptions, and setbacks caused either by a dysfunctional life style and interpersonal environment or by chance (Koerner & Linehan, 1997).

At the other pole of the dimensions are more inhibited behavioral patterns. Individuals characterized by inhibited grieving have a tendency to inhibit or overcontrol emotional responses, especially when confronted with loss or abandonment. The active passivity pattern refers to a failure to engage in active problem solving, that is, a repeated experiencing of helplessness and hopelessness that leads to active attempts to seek help from others in the environment. Last, the apparently competent BPD individual has a tendency to appear much more competent than he or she actually is. This results from a failure of competencies to generalize across moods or situations as well as from a failure to display nonverbal cues of emotional distress (McMain, Korman, & Dimeff, 2001).

**Overview of Intervention and Specific Techniques**

**Treatment Overview**

DBT providers attend to problems of clients in two ways: by enhancing capabilities and by increasing motivation. This approach is structured around five
essential functions: (a) expanding the individual’s repertoire of skilled behavioral patterns and (b) ensuring that new behaviors generalize from the therapeutic to the natural environment. In addition, treatment functions to improve the client’s motivation by (c) reducing reinforcement for dysfunctional behaviors and for high-probability responses (cognitions, emotions, actions) that interfere with effective behaviors, (d) structuring the environment so that effective behaviors, rather than dysfunctional behaviors, are reinforced, and (e) enhancing the motivation and capabilities of the therapist so that effective treatment is rendered (Linehan, 1993a).

These five functions are served by four treatment modes: individual psychotherapy, skills training group, phone coaching, and the therapist consultation team. Individual psychotherapy focuses on increasing motivation. The counselor structures motivational work around the client’s goals and collaboratively identifies and modifies contingencies that maintain behavior incompatible with the client’s goals. In addition, the client and the counselor work on structuring the environment such that the client gets reinforcement for behaviors compatible with achieving his or her goals. The importance of structuring therapy around the client’s goals cannot be understated. DBT helps the client achieve a life worth living, which cannot be determined by the counselor’s goals; it can be defined only by the client’s goals and values (Linehan, 1993a).

Changing contingencies to be more in line with building a life worth living is often more difficult because the client lacks capabilities to implement such change (Koerner & Linehan, 1992). Therefore, skills training concentrates on enhancing the client’s capabilities by teaching new skills. Briefly, during the emotion regulation training, clients learn a range of behavioral and cognitive strategies for reducing unwanted emotional responses as well as impulsive dysfunctional behaviors. Clients are taught how to identify and describe emotions, how to stop avoiding negative emotions, and how to increase positive emotions. Distress tolerance training teaches a number of impulse control and self-soothing techniques aimed at surviving crises without using drugs, attempting suicide, or engaging in other dysfunctional behavior. During interpersonal effectiveness training clients learn a variety of assertiveness skills they can use to achieve their objectives while maintaining relationships and self-respect. Last, clients learn mindfulness skills. This core group of skills includes wise mind, “what” skills, and “how” skills. Wise mind can be most easily defined as the inner wisdom within each individual. Clients are taught to acknowledge the value of both cold, calculating logic and mood-dependent thinking. “What” skills teach clients the types of mindfulness practices—namely, observing themselves or their immediate context, describing observations,
and participating spontaneously and completely. “How” skills explain how to practice mindfulness—that is, nonjudgmentally, one-mindfully (completely in the present moment), and effectively (by focusing on what works; Linehan, 1993b). In the third mode of DBT, phone coaching, the individual treatment provider uses phone consultations to help clients generalize skills in all relevant contexts.

Last, the motivation and capabilities of the treatment provider must also be enhanced for effective treatment to occur. The therapist consultation team is designed to offer support for the provider in treating the client effectively by preventing dysfunctional behavior, burn out, or rigidity on the part of the provider (Linehan, 1993a, 1993b).

**Specific Techniques**

DBT is essentially a problem-solving treatment balanced by validation and held together by dialectical strategies. Communication techniques and case management strategies are also integral parts of DBT. In addition, DBT has specific protocols for handling crises and egregious behavior (Linehan, 1993a). Specific techniques are derived from each group of strategies, and therefore we use the terms interchangeably. In DBT, strategies are principles that guide you in specific situations.

**Change Strategies.** Strategies for problem solving are drawn from cognitive-behavioral treatments and include contingency management, skills training, exposure, cognitive modification, commitment, and behavioral analysis. DBT adds to typical CBT change strategies: (a) targeting, (b) attention to in-session behavior, (c) chain analysis, (d) opposite action, and (e) observing limits.

**Targeting.** The structure of DBT sessions is based on a target hierarchy that eases decision making while ensuring that the most crucial problems are addressed. The counselor filters the potential issues to address by categorizing them according to a hierarchy and starting at the top. The hierarchy is different in individual therapy, skills training, or phone coaching. In individual therapy, the target hierarchy is decreasing suicidal behavior and any other imminent life-threatening behavior (e.g., murder), reducing therapy-interfering behaviors, reducing quality-of-life-interfering behaviors, and increasing behavioral skills (Linehan, 1993a).

Suicide attempts, threats, ideation, self-harming behaviors, and the client’s expectations about the value of suicide are directly targeted and never ignored. To maintain a dialectical stance, the counselor reaches for a synthesis between the beneficial short-term effects of suicidal behavior and
the negative long-term effects. Typically, a synthesis would be to replace suicidal behaviors with a more adaptive strategy for short-term relief (Linehan, 1993a).

Reducing therapy-interfering behaviors (TIBs) is aimed at facilitating treatment. TIBs may come from either the client or the therapist and include nonattentive, noncollaborative, and noncompliant behaviors, any behaviors that burn the therapist out or that create therapeutic imbalance, and behaviors that show a lack of respect for the client (Linehan, 1993a).

The third set of targets are aimed at reducing complex, pervasive behavioral patterns, including Axis I disorders, that have a severe effect on the quality of life of the client. Last, an increase in behavioral skills is needed for an effective life (Linehan, 1993a).

**Attention to in-session behavior.** What occurs in-session is considered important when it is either a TIB or a target-relevant behavior. Clients will often emit both problematic behaviors and target behaviors with the counselor present. DBT counselors attend to such behaviors as they occur by highlighting them and drawing connections to out-of-session behavior and by applying contingencies to them (Linehan, 1993a). For example, one of our clients had difficulties with saying no to requests made to her. She would agree to anything asked of her and then, if she could not do it, she avoided the person and the situation. This pattern caused many problems in her relationships. When she told her counselor she could not reschedule one session for an earlier hour because it would be unlikely she would be able to wake up, the counselor made a point of highlighting how she said no and how she prevented damaging the relationship, which she could have if she had agreed to it and then did not show up. By reinforcing an effective way to handle a situation in-session that was typically ineffectively handled outside of session, the counselor increased the likelihood that the effective behavior would occur more often.

**Chain analysis.** In a behavioral chain analysis, a specific instance of a behavior is assessed in great detail. The therapist starts by asking the client when the problem began (the precipitating event) and continues by assessing each link in the chain of events by getting detailed descriptions of the environment and client’s behavior, including the consequences (Linehan, 1993a). This moment-by-moment assessment helps the therapist and client more clearly identify the causes and contingencies that are maintaining the problematic behavior (for a full discussion of behavioral chain analysis, including a detailed example, see Linehan & Dexter-Mazza, 2008, p. 395).

**Opposite action.** Opposite action is aimed at reducing unwanted negative emotions. The assumption behind it states that acting in accordance with the action urge that is associated with an emotion increases the likelihood that that
emotion will fire again (Linehan et al., 2007). This formulation is similar to current conceptualizations underlying exposure and response prevention in that it involves actively replacing an emotion-consistent behavior with an emotion-inconsistent behavior (e.g., Foa, 2000; Himle & Franklin, 2009). The difference between opposite action and exposure is that opposite action is defined and adapted for all emotions, not only fear. Therefore, if an emotion does not fit the facts of the situation or is dysfunctional, opposite action involves (a) exposure to the stimuli or cues evoking the emotion, (b) blocking of the behavior prompted by the emotion’s action urge, and (c) acting in a way that is opposite to or inconsistent with the emotional response (Linehan, 1993b).

For example, the action urge of fear is to avoid. The opposite action is to fully approach the situation. For anger, the action urge is to attack and have judgments about the situation. The opposite action to anger involves gently removing oneself from the anger-provoking situation and engaging in activities that are incompatible with anger, such as unclenching fists and opening the palms of hands, relaxing shoulders, making understanding or empathic statements, or actively working to generate caring or understanding for the person with whom the client is angry. Over time, the very stimuli that initially elicited anger become conditioned to a lower intensity of anger and potentially to incompatible emotions (e.g., empathy; Linehan et al., 2007).

**Observing limits.** Limits in DBT are similar to the concept of boundaries found in many treatments. Limits may vary from one counselor to another and across time and context. In more formal terms, observing limits implies applying problem-solving strategies and contingency management procedures to client behaviors that threaten to interfere with the counselor’s ability or willingness to provide therapy. Limits are typically identified when they are crossed (Linehan, 1993a). For example, occasional calls during the night were not crossing a counselor’s limits until one client started calling her every night in the middle of the night. Very quickly, the nighttime phone behavior was irritating to the point that the counselor was dreading seeing the client. Therefore, calling in the middle of the night became crossing the limits for the counselor. In DBT, an instance such as this requires that the counselor address it in treatment. Counselors take responsibility for monitoring their own personal limits and for communicating to their clients which behaviors are tolerable and which are not. DBT counselors also extend their limits temporarily when needed (Linehan, 1993a). For example, even if it crossed the counselor’s limits to be called in the middle of the night, in an emergency the call would be taken.

**Validation Strategies.** In DBT, change strategies are balanced with validation strategies. Validation requires empathy, but goes beyond it by accurately
recognizing what is well grounded or justifiable and acknowledging and authenticating what is (Dimeff & Linehan, 2001). Through validation the therapist communicates to the client what responses make sense and are understandable within the current context. This does not mean validating something that is untrue to make the person feel better (Linehan, 1997).

There are six levels of validation. The first four are common techniques used in most acceptance-based therapies. At Level 1, the therapist listens and observes what the client is saying and acts interested in the client. At Level 2, the therapist accurately reflects back to the client her feelings, thoughts, assumptions, and behaviors.

Level 3 validation emphasizes articulating the unverbalized. Many clients have been invalidated so often throughout their lives that they doubt the experiences that they are having. When the treatment provider articulates the unverbalized, he or she communicates that the response the client probably experiences is indeed valid. For example, for a client coming from a family who punishes emotional expression, having a provider say “you are probably sad” when the client is talking about a close friend moving away may authenticate the client’s experience. This technique has the effect of assuring the client that his or her responses are normal, predictable, and justifiable. At Level 4, the provider validates behavior in terms of its causes. At this level, behavior is understandable in terms of historical antecedents but may not make sense in terms of current antecedents (Linehan, 1997; e.g., “It makes sense you’re ashamed to say no to your partner because in the past people broke up with you if you said no”).

The last two levels of validation are more particular to DBT and emphasize a much more profound validation to the person. Level 5 validation recognizes behavior, thoughts, and emotions that are valid in terms of current circumstances. In other words, Level 5 validation normalizes the client’s valid experience (e.g., “Most people would get angry at a rude clerk”). Level 6 validation is called radical genuineness. At this level the counselor treats the person as valid, by recognizing the person as he or she is, seeing capabilities, and understanding actual difficulties and incapacities. DBT puts a great value on the counselor not taking the role of “therapist” but acting like a genuine person (Dimeff & Linehan, 2001; Linehan, 1997). Linehan makes the same argument as Carl Rogers (Rogers, 1961), that therapists must be genuine and authentic such that if an outside observer were to compare the interaction style between a client and a therapist and the same therapist and a colleague, the observer would find little difference between the two.
**Dialectical Strategies.** Dialectical strategies are crucial to the treatment. They help balance acceptance and change strategies and guide the therapist to be on the lookout for polarity that may occur. Also, from a dialectics perspective, the therapist is always asking for what is left out when searching for causes. Specific strategies help the treatment provider with this task and are put into practice using an irreverent communication style.

Extending is a specific strategy where the provider focuses on a different portion of the client’s communication than what was obviously intended. Usually, this is helpful when the client says something for the dramatic effect to induce some change in the therapist (Linehan, 1993a). For example, after a threat to walk out of the room if the therapist does not stop the chain analysis, the therapist might ask what exactly he or she is to do with the rest of the session if the client is outside. Alternatively the provider might say, “Oh dear! I did not realize this is so upsetting to you! Maybe we should talk about finding you another therapist that doesn’t require you to do this after you hurt yourself.”

Another dialectical strategy, devil’s advocate, is used to strengthen a client’s view or a client’s commitment. The counselor takes a position that is opposite to the client’s and argues for it to help the client move toward the synthesis (Linehan, 1993a; e.g., “So glad to hear you’re committing to not kill yourself for the next year! Are you sure about that though? It’s going to be awfully hard. . . .”).

Used to highlight the opposite point or the path to synthesis, metaphors are used when talking literally about what is happening is too difficult for the client (Linehan, 1993a). For example, the counselor may describe that the client’s misery is like being on a bed of burning coals in the middle of hell. Furthermore, the counselor might explain that a better use of therapy time is to drag the client out of this hell rather than to pour a bucket of water over the client’s feet. This may help a client better understand the importance of problem solving crisis situations rather than simply getting reassurance and compassion.

Last, the therapist may help the client make “lemonade out of lemons” by finding how the client could create value in a situation where value is difficult to find. Therapists must be alert not to sound like they are not taking clients’ problems seriously (Linehan, 1993a). For example, if a client complains about a terrible fight with a partner, the therapist might say, “It is unfortunate that it happened again! It must have been hard to go through it. The good news is, now we can have a specific instance to figure out why you’re unskillful in fights.”
**Communication Strategies.** In DBT, communication to the client is balanced between reciprocal and irreverent styles. Irreverence is incongruous and unexpected and is used when therapy is stuck or the client is rigid. The function of irreverence is to capture the client’s attention, shift his or her affective response, and get him or her to see a different point of view. Irreverence must be surrounded with validation and must be genuine and nonjudgmental (Linehan, 1993a).

Specific irreverence strategies are reframing, plunging in where angels fear to tread, using a confrontational tone, calling the client’s bluff, and highlighting omnipotence versus impotence (Linehan, 1993a). For example, if the client threatens suicide, the counselor might respond using reframing, “What do you mean you want to kill yourself? You promised not to quit therapy!” which focuses on a different portion of the message than what the client intended; or plunge where angels fear to tread, “Look, you’re ruining your chances of having any close relationships with people if you keep threatening to kill yourself whenever things don’t go your way”; or use a confrontational tone, “Are you out of your mind???”; or call the client’s bluff (provided the counselor is certain it is a bluff), “Would you like to end the session now?”; or highlight impotence of the therapist, “You could kill yourself, the problem with that would be that I haven’t learned yet how to help dead people.” Detailed descriptions of these strategies as well as further examples can be found in the DBT manual (Linehan, 1993a).

Reciprocal communication strategies balance irreverence as well as the power differential by making the treatment provider more vulnerable in session. There are five ways in which this purpose is accomplished: responsiveness, self-involving self-disclosure, personal disclosure, warmth, and genuineness. Responsiveness is defined by responding to the content of the client’s concerns: staying awake and taking the client’s agenda seriously. Self-involving disclosure refers to statements about the provider’s reactions to the client (e.g., “When you do X, I feel Y”). Personal disclosure refers to communicating information about yourself, as long as it is in the client’s best interests. Warmth is communicated by voice tone, posture, and conversation style; the counselor must remain warm even when the session is difficult. Last, genuineness asks one to bring oneself and not their therapist self into session (Linehan, 1993a).

**Case Management Strategies.** There are three case management strategies: consultation to the client, environmental intervention, and the consultation team. Case management is needed to help counselors navigate relationships with other professionals involved in the client’s case. In DBT, a counselor will
intervene in the client’s environment only under very specific conditions: (a) the client is unable to do so and the outcome is extremely important, (b) the environment demands someone in high power, (c) the client’s life or others are in imminent danger, (d) it is the humane thing to do and will cause no harm, or (e) the client is a minor. In all other instances, the counselor typically consults with the client and coaches him or her on how to interact but does not consult with other providers on how to interact with the client. In this way, the client learns how to interact more skillfully with his or her environment (Linehan, 1993a).

Research Support

Research Supporting Efficacy and Effectiveness: DBT With BPD

DBT is by far the best studied treatment for BPD. To date, DBT has been evaluated in both 1-year and 6-month treatment lengths in 10 randomized controlled trials (RCTs) conducted across six independent research teams. Four of these trials specifically recruited highly suicidal BPD clients (Linehan, Armstrong, Suarez, Allmon, & Heard, 1991; Linehan et al., 2006; McMain et al., 2009; Turner, 2000). Compared to treatment as usual (TAU), DBT participants were significantly less likely to attempt suicide or self-injure, had less medically severe suicidal behavior episodes, had lower treatment dropout, tended to use psychiatric facilities less, and improved more on scores of global and social adjustment. Improvements in hopelessness, depression, suicidal ideation, and reasons for living did not differ between treatments (Linehan et al., 1991; Linehan, Heard, & Armstrong, 1993).

Compared to client-centered therapy (CCT), DBT reduced suicidal behavior, depression, anger, use of crisis services, and impulsiveness and improved social adjustment significantly more than CCT. In the same study, CCT did not outperform DBT in any assessment, although there was no significant difference in anxiety between conditions (Turner, 2000).

Despite promising results, DBT has been criticized for having unclear mechanisms of change (Scheel, 2000) and for not having sufficient follow-up data to support its long-term effectiveness (Westen, 2000). The prestige of the university setting, experience of therapists, provision of supervision, and extensive training are also presented as potential confounds in studies of DBT (Scheel, 2000).

To address these confounds, Linehan designed a control condition with equal training, prestige, experience, and amount of supervision. When compared to
treatment by nonbehavioral community experts, DBT reduced suicide attempts by half and resulted in less medically severe self-injurious episodes and in fewer admissions to both emergency departments and inpatient units because of suicidality. There was equal improvement in suicidal ideation and depression in both conditions. These gains were maintained through 1 year of follow-up (Linehan et al., 2006).

McMain and colleagues (2009) also compared DBT with brief psychodynamic-oriented therapy plus medication management for highly suicidal BPD clients. They found significant reductions following treatment in suicidal behavior, health care utilization, depression, borderline psychopathology, and anger but no difference between the two conditions. Treatment gains were also maintained through-out 1 year of follow-up.

DBT was adapted to also address comorbid substance use disorder (SUD). Changes included the application of dialectics to issues surrounding abstinence, an added set of substance abuse behavioral targets, an additional set of attachment strategies for the easy-to-lose clients, and modification of some skills to more directly address substance abuse problems (Dimeff, Rizvi, Brown, & Linehan, 2000). Two RCTs and a controlled trial have assessed DBT’s effectiveness with BPD-SUD individuals (Dimeff et al., 2000; Linehan et al., 1999; Linehan et al., 2002; Van den Bosch et al., 2005).

Linehan and colleagues (1999) compared DBT to TAU for methamphetamine-dependent suicidal women with BPD. Two times more participants dropped out of TAU (73%) than DBT. Furthermore, urinalyses suggested a statistically significant reduction in drug abuse for DBT clients when compared to TAU clients. Follow-up also indicated significant improvement in social and global adjustment.

A second RCT (Linehan et al., 2002) compared DBT with Comprehensive Validation Therapy with 12-Step (CVT_12S) in heroin-addicted BPD women. All participants were concurrently on LAAM (an opiate agonist). Results of urinalyses indicated that both treatment conditions were effective in reducing opiate use relative to baseline. At posttreatment, all participants had a low proportion of opiate-positive urinalyses and a significant decrease in psychopathology. DBT and CVT_12S were equivalent in their reduction of drug use throughout the treatment, but DBT was significantly better at maintaining these gains at follow-up than CVT_12S.

Van den Bosch and colleagues (2005) also showed that DBT outperformed TAU on retention rates and decreased borderline psychopathology during 1 year of treatment. DBT and TAU performed comparably during treatment and at follow-up with regard to decrease in suicidal behavior and substance abuse.
Among less severe BPD patients, DBT reduced suicide ideation, hopelessness, anger expression, and amount of hospitalization to a greater degree than TAU (Koons et al., 2001), improved treatment retention, self-damaging impulsivity, and borderline features (Verheul et al., 2003), and decreased suicidal ideation and urges to self-harm (Stanley, Brodsky, Nelson, & Dulit, 2007). Across these studies, DBT did not differ from non-DBT control conditions in reduction of suicidal behavior.

Furthermore, standard DBT increased treatment retention more than DBT skills combined with psychodynamic individual therapy (Harley, Baity, Blais, & Jacobo, 2007), although DBT skills only was sufficient to outperform standard group therapy in improving dropout, depression, anger, and affect instability (Solero et al., 2009). The addition of olanzapine to DBT may hasten the reduction of irritability in BPD women (Linehan, McDavid, Brown, Sayrs, & Gallop, 2008), but the addition of fluoxetine does not appear to add any benefit (Simpson et al., 2004).

DBT can be successfully implemented in community settings, showing similar results there to those obtained in tightly controlled trials. In an Irish community setting, inpatient visits, symptom severity, and self-harm were significantly improved after 6 months of DBT (Blennerhassett, Bamford, Whelan, Jamieson, & Wilson O’Raghaillaigh, 2009). Furthermore, a 77% decrease in hospital days, a 56% decrease in crisis bed days, and an 80% decrease in face-to-face contact with emergency services were also reported by a community center implementing DBT (American Psychological Association, 1998).

A 3-month inpatient adaptation has also shown significant decreases from pre- to posttreatment in depression, anxiety, global stress, and suicidal behavior (Bohus et al., 2000) with up to a 50% decrease in self-harm (Alper & Peterson, 2001). Inpatient DBT performs the same as TAU in reducing dissociation and anger, while showing significantly steeper improvements in all other areas (Bohus et al., 2004). A forensic adaptation has also shown promise for violent BPD men. In one controlled trial, DBT reduced the seriousness of violent incidents and the hostility and anger self-reports significantly more than TAU (Evershed et al., 2003).

**DBT With Other Populations**

In addition to empirical support for the effectiveness of DBT with BPD, the treatment has been evaluated and shown to be a promising treatment for use with other populations. Adaptations of DBT were found to be effective treatments for bulimia nervosa (Safer et al., 2001), binge eating disorder (Telch, Agras, & Linehan, 2001), major depressive disorder with (Lynch et al., 2007)
and without comorbid personality disorders (Harley, Sprich, Safren, Jacobo, & Fava, 2008; Lynch, Morse, Mendelson, & Robins, 2003), domestic abuse victims (Iverson et al., 2009), vocation rehabilitation (Koons et al., 2006), stalking offenders (Rosenfeld et al., 2007), difficult-to-manage correctional populations (Shelton et al., 2009), and families of suicidal patients (Rajalin et al., 2009).

The majority of the adaptations offered only the skills training component of DBT. An exception was the study by Rosenfeld and colleagues (2007), who provided the full DBT package and found that program completers were significantly less likely to have another stalking offense in the 6-month follow-up than program noncompleters or population norms. A second exception is found in two studies presented by Lynch and colleagues (2007). In the first study, DBT skills and DBT phone coaching were added to antidepressants and compared to antidepressants alone for an elderly, depressed sample. In the second study, standard DBT with medication was compared to medication alone for an elderly, depressed sample with comorbid personality disorders. In both studies, the authors found that depressed individuals remitted much faster when treated with DBT and medication than when treated with medication alone.

In all the other studies, skills-only adaptations of DBT improved pre- to posttreatment ratings of depression, hopelessness, and general distress in victims of domestic abuse (Iverson et al., 2009); depression, hopelessness, anger, and number of hours worked in vocational rehabilitation clients (Koons et al., 2006); perceived burden, psychic health, and well-being in family members of suicidal individuals (Rajalin et al., 2009); and aggression, impulsivity, and psychopathology in difficult-to-manage correctional populations (Shelton et al., 2009). When compared to TAU or a wait list condition, DBT significantly increased abstinence from binging and purging in females with eating disorders (Safer et al., 2001; Telch et al., 2001) and decreased depression in treatment-resistant depressed individuals (Harley et al., 2008).

**Issues of Individual or Cultural Diversity and Social Justice**

Culturally sensitive treatments need to be adaptable to the individual and compatible with the worldview of clients. DBT is easily adaptable to fit the culture of the client because it is based on principles (rather than a fixed session composition), a collaborative nature, and a flexible structure. Although it is possible for principles to be culture-bound constructs, the principles on which DBT
has been developed (i.e., learning theory, change, acceptance, mindfulness, dialectics) are broad and, as such, flexible to the particular needs and style of both counselor and patient. The treatment does not impose rigid session plans or curricula; instead, it guides the counselor in how to respond through principles and strategies. The counselor has freedom to choose what to do in each session, and adherence to the treatment comes from following the DBT framework rather than from specific content.

DBT is structured around the client’s goals and aspirations, adding further potential for DBT to be applicable across diverse cultures. The targeted outcome for a DBT client is not to fix his or her problems following a set of arbitrary criteria. The outcome is to help the client get what he or she wants, or to get closer to obtaining it. Because of this emphasis on client values and goals, DBT is easily applicable to all clients regardless of race, ethnicity, or gender. DBT helps clients achieve their individual goals without imposing social expectations of the dominant culture. In this way, DBT supports social justice.

DBT was developed on primarily Eurocentric samples. Nevertheless, the transactional interaction between BPD individuals and the environment, explained in the biosocial theory, could be easily adaptable to other patterns of interaction more common to different cultures. For example, at least in theory, the Afrocentric worldview (Myers, 2003) seems compatible with the way DBT is structured and presented to clients, making it possibly more palatable for African American minorities than standard treatments. First, DBT is compatible with the holistic nature of the Afrocentric worldview by positing that reality can be known through sensory and spiritual means. Second, interpersonal relationships, cooperation, communalism, and harmony with nature are valued in the Afrocentric worldview, as well as in DBT, giving additional common ground for the two philosophies to overlap (Martin, 2006). However, despite these observations, research is needed to assess whether DBT is indeed compatible with an Afrocentric worldview.

Turner, Barnett, and Korslund (1998) present potential modifications to make to DBT to use it with minority youth populations. They recommend that the therapist use dialectical thinking, without teaching it to the clients; use concrete language and concrete thinking to teach skills; do individual rather than group skills training; be more actively involved in the patient’s community system; and be flexible about the length of treatment. They present case examples of how adding these modifications to DBT has led to improvements in minority adolescents.

Only one study examined whether ethnicity and other demographic characteristics predict major outcomes in DBT. Ethnicity, education, age, and
marital status did not predict change in remission, dropout, self-injury, and suicide attempts following DBT treatment for 96 participants (Harned, Salsman, Secrist, Comtois, & Linehan, 2006). These findings suggest that DBT outcomes are similar for minority populations.

Yet overall, evidence bearing on whether DBT needs to be further adapted for culturally diverse populations is scarce. This is a major limitation of current DBT findings and a fruitful area for further research. Although in theory DBT should be easily applicable to other cultures, issues such as directness of the therapist, appropriateness of self-disclosure, and value given to personal goals may need to be addressed in working with clients from less westernized cultures. Thus far, DBT has been successfully adapted to a prison setting (e.g., Quinn & Shera, 2009), suggesting that it has potential to be translatable to populations with different needs.

An important cultural issue to consider with the application of DBT is that at the core of the treatment are mindfulness and acceptance practices drawn from a Zen philosophy. Awareness of the present moment and radical acceptance are taught to clients as skills, and counselors are required to practice them. Although this emphasis may be perfect for some clients from non-Western origins, what happens if counselors or clients have a different world perspective and are not fluent in Zen practices or Buddhism? Although these skills were drawn from Zen principles, they are compatible with and can be translated into and explained through most spiritual practices, or using a framework that emphasizes theory and research from behavioral sciences. For example, for a spiritual client, mindfulness practice can be equivalent to prayer (where one throws oneself into praying), contemplative meditation, or a wide-awake observation of a church ceremony. Clients and counselors can be past, present, or future oriented, as long as they are doing this mindfully.

If the client or counselor is not spiritual, mindfulness practice can be explained through psychological research. For example, mindfulness training and practice decreases worry (Evans et al., 2008), enhances self-regulation (K. Brown & Ryan, 2003), increases positive emotions, and strengthens the body’s immune system (Davidson et al., 2003).

**Summary**

In summary, DBT is an evidence-based, principle-based treatment that integrates behavioral theory with dialectical philosophy and Zen principles. The treatment evolved from dissatisfaction with standard CBT for a difficult-to-treat population. Validation and contemplative practices were added, and a dialectical philosophy emphasizing the synthesis of opposites was used to
balance change with acceptance. Owing to the difficulty of working with BPD clients, behavioral change was balanced with acceptance through dialectics and stylistic strategies, while simultaneously providing a framework for case management and support for counselors. DBT incorporates four treatment modes (individual, skills, phone coaching, therapist consultation team) aimed at addressing the behavioral difficulties of BPD clients primarily by enhancing client and counselor motivation as well as by increasing the behavioral repertoire clients need for effectively reaching a life worth living.

Research supports the DBT model and findings on adaptations of DBT suggest that such techniques are helpful with a variety of other patient groups. In theory, the principles and structure of DBT should be translatable to minority populations as well. Nevertheless, more research is needed to understand how DBT applies to such groups and how it supports principles of social justice.

Counseling psychologists work in a variety of applied settings. Although at first DBT may seem somewhat counter to the underlying philosophy of the specialty, it is a reality that counseling psychologists are likely to work with clients who have diagnoses of BPD or features thereof. DBT would bring a useful set of skills and knowledge in these situations. Furthermore, the general principles of DBT can be used with any client by simply skipping aspects that are not particularly relevant to the client’s presentation (e.g., where suicidal ideation or self-harming behavior is not present). The specific techniques presented (e.g., chain analysis, validation, skills training) can be helpful with a diverse group of clients. As research has demonstrated, DBT is helpful in a wide array of settings for a wide array of populations.

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