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In ths section we feature papers based on the keynote conference presenters Professor Pat Dudgeon, Dr Erana Cooper and Dr Alan Fruzzetti who presented at the joint NZPsS/NZCCP conference in April this year. We also present papers on smoking cessation, research into the success of Māori achievers, the Psychologist Board's accreditation of training programmes and students' of clinical psychology theses abstracts.

Indigenous Australian Mental Health and Racism: There Could be Cathedrals of the Spirit as Well as Stone

Pat Dudgeon

Professor Pat Dudgeon is an Indigenous Australian Psychologist from Bardi people of the Kimberley. She is known for her role in higher education and in Indigenous Psychology. She was appointed as Head of the Centre of Aboriginal Studies at Curtin University in 1990. Pat was the first Indigenous convenor of the Australian Psychological Society Interest Group, Aboriginal Issues, Aboriginal People and Psychology. She is currently the founding chair of the Australian Indigenous Psychologists' Association auspiced by the Australian Psychological Society.

Abstract

In 1977, Koori activist and scholar, Kevin Gilbert wrote about the impact of colonisation upon Australian Indigenous peoples:

> *[Aboriginal and Torres Strait Islander people] were hit by the full blight of an alien way of thinking. They were hit by the intolerance and uncomprehending barbarism of a people intent only on progress in material terms, a people who never credited that there could be cathedrals of the spirit as well as stone. (1977, pp.2-3)*

This paper critically examines the role of psychology in colonisation and where the discipline has come over the last three decades of unprecedented social and political change. An overview of Indigenous mental health is provided with a focus on the social determinants of health, particularly racism. Indigenous Australians face forms of individual, institutionalised and cultural racism every day. This paper comes from a position that research and practice in psychology has historically perpetuated inequities and racism in health and mental health. However, our discipline can be part of the solutions in the future.

Considerable changes are required to bring about equity in the way that health and mental health care is provided for Indigenous Australians. Some changes can be immediate such as the provision of quality cultural competence training with the mental health workforce. This presentation will overview other changes, including paradigms shifts that auger well for inclusivity of the discipline.

Introduction

Indigenous Australia is made up of two cultural groups; mainland Aboriginal people and Torres Strait Islander people. This paper uses the term 'Indigenous', unless referring to

mainland Aboriginal people.

Any discussion of the current mental health of Indigenous Australian people requires an understanding of its broader historical and cultural context. The history of colonisation and the subsequent devastation of Indigenous Australians, their resilience and their struggle to claim equality and cultural recognition shape circumstances today.

Major themes addressed in this paper include: the demographic, historical and cultural context of Indigenous Australia; Indigenous mental health as a product of that context; and more recent directions in Indigenous mental health.

Colonisation in Australia meant the loss of lands, languages, social systems and basic human rights and freedom.

Overall, Indigenous people make up 2.5 per cent of the total Australian population. The Australian Bureau of Statistics estimated that in 2006 there were 517,200 Aboriginal and Torres Strait Islander people living in Australia. Of these, it was estimated that:

- 463,900 (90 per cent) were of Aboriginal origin;
- 33,100 (6 per cent) were of Torres Strait Islander origin only; and
- 20,200 (4 per cent) were of both Aboriginal and Torres Strait Islander origin (Australian Bureau of Statistics, 2006).

Most Indigenous people live in major cities and while the majority live in urban settings, the Indigenous population is much more widely dispersed across the country than the non-Indigenous population. Additionally, Aboriginal people comprise a much higher proportion of the population in more remote areas and Northern Australia.

Aboriginal Cultural History

Aboriginal people have been in Australia for between 50,000 to 120,000 years, with approximately 300,000 Aboriginal people living in Australia when the British arrived in 1788. During colonisation it is estimated that the numbers declined to around 75,000.

Aboriginal Australians were hunter-gatherers who lived in small groups. Membership within each family or language group was based on birthright, shared language, and cultural obligations and responsibilities. Complex and sophisticated kinship systems placed each person in relationship to every other person in the groups and determined the behaviour of an individual to each person. (Berndt & Berndt, 1992).

According to Aboriginal beliefs, the physical environment of each local area was created and shaped by the actions of spiritual ancestors who traveled across the landscape. Helen Milroy, the only Aboriginal psychiatrist in the country, speaks of the importance of land as part of the Dreaming:

> *We are part of the Dreaming. We have been in the Dreaming for a long time before we are born on this earth and we will return to this vast landscape at the end of our days. It provides for us during our time on earth, a place to heal, to restore purpose and hope, and to continue our destiny. (Human Rights and Equal Opportunity Commission 2008, p. 414)*

Colonisation: Resistance and Adaptation

European settlement brought introduced diseases, different social practices and beliefs. It also brought policies of extermination and massacre, protection and assimilation. Colonisation in Australia meant the loss of lands, languages, social systems and basic human rights and freedom.

European settlement moved from Botany Bay outwards as settlers claimed land. The pastoral industry escalated the expansion, bringing increases in British immigrants. Broome (1994) calls the rapidly moving frontier of the mid-1800s as the most 'fantastic land grab, never again to be equaled' (p.37).

As their lands became increasingly occupied, Aboriginal people gravitated towards European settlements as their own food supplies were disrupted and they sought to access the convenience of European foods, tobacco and implements. Extremely high death rates and low birth rates led to their population decline to the estimated 75,000 at the turn of the twentieth century. Aboriginal people were perceived by the dominant society as hopeless remnants, clinging to what was left of their cultures and merely surviving. While there are many examples of Aboriginal groups across the country successfully adapting to colonization, Aboriginal people were then subjected to government policies that attempted over time to displace, 'protect', disperse, convert and eventually assimilate them.

Oppressive Legislation

At Federation, Australian states and territories had control and responsibility for Indigenous Australians. Each State of the newly formed Federation framed and enacted suites of legislations and policies that were punitive and restrictive towards Indigenous peoples. The effects were a form of cultural genocide of Indigenous Australians, through the loss of language, family dispersion and the cessation of cultural practices.

History demonstrates how racist beliefs became law. Aboriginal people were believed to be less than human,

and legislation was used to control them and confine them away from 'the public'. The Western Australian Aborigines Act 1905, for example, has special connotations today because of its gross erosion of rights, resulting in forcible removal of children and imprisonment of Aboriginal people onto reserves of servitude and despair. 1905 marked the start of a period of formidable surveillance and oppression of Aboriginal people. The Aborigines Act 1905 was not a protection for Aboriginal peoples, but an instrument of ruthless control. Very few Aboriginal people escaped the direct and indirect effects of the legislation that controlled and governed their lives.

It should be noted that Indigenous people and white supporters have continued to resist and struggle for justice since colonisation. The movement for Indigenous rights began in the 1920s, with the establishment

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of Aboriginal political organisations, in particular the Australian Aborigines League led by William Cooper and the Aborigines Protection Association with William Ferguson (Bullimore, 2001). Over time, various Indigenous political and support groups were established across the country.

The 1967 Commonwealth Referendum

In Australia, the 1967 Commonwealth Referendum symbolises the granting of full citizenship rights to Australian Aboriginal peoples. The 1960s and 1970s saw significant achievements that have now become historical moments in the struggle for Aboriginal rights. These include the establishment of the Aboriginal Tent Embassy in Canberra, the creation of the Aboriginal flag by Harold Thomas in 1971, and land rights legislation. The trauma that Aboriginal people have suffered through colonisation, past policies and ongoing social disadvantage and racism is seen in contemporary situations. Kelvin Gilbert, a Koori academic, summarised the situation of Indigenous people as early as 1977.

> *[T]hey were hit by the full blight of an alien way of thinking. They were hit by the intolerance and uncomprehending barbarism of a people intent only on progress in material terms, a people who never credited that there could be cathedrals of the spirit as well as stone. Their view of Aborigines as the most miserable people on earth was seared into Aboriginal thinking because they now controlled the provisions that allowed blacks to continue to exist at all. Independence from them was not possible... It is my thesis that Aboriginal Australia underwent a rape of the soul so profound that the blight continues in the minds of most blacks today. It is this psychological blight, more than anything else that causes the conditions that we see on the reserves and missions. And it is repeated down the generations. (Gilbert, 1977, pp. 2-3).*

Despite the reclamation of Indigenous culture, the traumas suffered during the process of colonisation, the loss and disruption of cultural traditions and loss of land still affects Aboriginal people today.

Health and Social Indicators

Where are we now? Not in a good place to say the least. Our statistics are appalling. We know things are bad but the statistics confirm our perceptions. The national *Overcoming Indigenous Disadvantage Report: Key Indicators 2005/2007/2009 Reports* (SCRGSP, 2005, 2007 & 2009) provides a useful statistical database and shows that Indigenous people are the most disadvantaged group in Australia around key indicators such as: life expectancy; infant mortality; suicide death and self-harm rates; homicide death rates; especially involving alcohol; hospitalisation related to assault and alcohol abuse; and incarceration rates.

Despite the reclamation of Indigenous culture, the traumas suffered during the process of colonisation, the loss and disruption of cultural traditions and loss of land still affects Aboriginal people today.

In mental health specifically, the statistics are appalling.

- In 2003-04 Aboriginal and Torres Strait Islander people were twice as likely to be hospitalised for mental health and behavioural disorders than other Australians.
- Hospitalisation rates for intentional self-harm may also be indicative of mental illness and distress. In 2005–06, Indigenous Australians were **three times** more likely to be hospitalised for intentional self-harm than other Australians.
- Deaths from intentional self-harm were much higher for Indigenous people than for non-Indigenous people in 2003-2007, particularly for males.
- Additionally, intentional self-harm accounted for a higher proportion of causes of death among Indigenous people than non-Indigenous people in each jurisdiction.

While Torres Strait Islander people have their own distinctive culture, they share many of the same disadvantages as Aboriginal people (Australian Bureau of Statistics 2006).

This litany of impoverishment and disadvantage in an otherwise wealthy nation is shameful. The situation has many causes and no easy solutions, but it is clear that decades of colonial exploitation and a prolonged systematic attempt to destroy Indigenous people and culture lie at the core of the causes.

Despite current campaigns, government policies and attempts at closing the gap on Indigenous health inequalities, as noted in the Overcoming Indigenous Disadvantage Report (SCRGSP 2009), racism at individual and institutional levels continues to reproduce the impoverishment and disadvantage experienced by most Indigenous Australians.

Racism

According to the Human Rights and Equal Opportunity Commission:

> *There are no universally accepted definitions of racism, racial discrimination, xenophobia and related intolerance. Racism exists in many different forms. Generally, racism is a set of beliefs, often complex, that asserts the natural superiority of one group over another, and which is often used to justify differential treatment and social positions. This may occur at the individual level, but often occurs at a broader systemic or institutional level. (HREOC website)*

Racism is not a simple concept; it is complex and historical. It is a significant issue and it is only recently that we have again put it on the table to look at ways we can bring about a society that owns its racism and that is open to begin to deal with it. In owning racism we can truly start the journey to become culturally sensitive and culturally competent. Personally, I believe efforts to become culturally competent are one of the strategies against racism. Professionally, I believe our professions of health and mental health (including government departments) are not culturally competent and are racist.

James Jones (1997), an African American psychologist, proposed that contemporary racism should be considered at three different levels - individual, institutional and cultural. These are distinguished by the intersections of psychological, behavioural, institutional, structural and cultural dynamics in the processes of racialised beliefs and practices.

In owning racism we can truly start the journey to become culturally sensitive and culturally competent. Personally, I believe efforts to become culturally competent are one of the strategies against racism.

Individual Racism

According to Jones, a racist individual is:

> *... one who considers that black people as a group (or other human groups defined by essential racial characteristics) are inferior to whites because of physical (i.e., genotypical and phenotypical) traits. He or she further believes that these physical traits are determinants of social behaviour and of moral or intellectual qualities, and ultimately presumes that this inferiority is a legitimate basis for that group's inferior social treatment, An important consideration is that all judgments of superiority are based on the corresponding traits of white people as norms of comparison. (Jones, 1997, p. 417)*

Often, people think that individual racism must be overt and blatant; that if it's not obvious then it's not racism. If only that were the case! Individual racism is more often than not subtle and covert, dressed in a veneer of tolerance and acceptance, but no less invidious in its consequences. Subtle racism is much harder to change, as it is rarely recognised as racism, by the perpetuator and/or by the wider community.

Institutionalised Racism

While individual people are, rightly, seen as the agents of racism, it is important to appreciate how racism operates at a cultural and an institutional level. Institutional racism refers more specifically to the practices and structures of a society's institutions:

> *... those established laws, customs, and practices, which systematically reflect and produce racial inequities in society. If racist consequences accrue to institutional laws, customs, or practices, the institution is racist whether or not the individuals maintaining those practices have racist intentions. Institutional racism can be either overt or covert ... and either intentional or unintentional. (Jones, 1997, p. 438)*

An institution can engage in racist practices without any of its members being individually racist. This is an important point to comprehend if we are to understand the damaging health and educational outcomes affecting Indigenous people. Low life expectancy, poor health overall, the high rates of unemployment, lower average income, low education and high rates of arrest and imprisonment are indicators of the consequences of entrenched institutionalised racism.

Cultural Racism

Culture is a part of the atmosphere of a society; a part of the tacit, assumed

way of doing things and comprised of the ideas, values, beliefs and shared understandings that together allow members of a culture to interact with one another. Accordingly, cultural racism:

> *... comprises the cumulative effects of a racialised worldview, based on belief in essential racial differences that favour the dominant racial group over others. These effects are suffused throughout the culture via institutional structures, ideological beliefs, and personal everyday actions of people in the culture, and these effects are passed on from generation to generation. (Jones, 1997, p. 472)*

The three levels of racism – individual, institutional and cultural – interact with each other. Most Indigenous persons, in Australia and in New Zealand can recount stories of racism they have suffered at all these three levels.

Professionally, we constantly deal with racism in our discipline. Clinton Schultz, an Aboriginal psychologist, undertook a survey of 15 Indigenous psychologists and found that 11 of them had been confronted with significant racism either in their studies or in their work places; such that they had to leave. I myself mentored two Aboriginal women psychologists. One was actively undermined in her employment in a workforce selection company where she was responsible for assessments. She tried unsuccessfully to introduce a cultural section into assessments for Aboriginal clients which was not accepted. As a consequence, her professional integrity was continually undermined regarding her assessments. This experience of racism was very deliberate. The other psychologist just started to feel alienated and wanted her work place to undertake cultural competence training (as soon as I hear another Aboriginal person saying that, I sense that they are feeling alienated and culturally unsafe). Her workplace was not deliberately racist, but it did not make provision to create a safe place for her. Once she identified how she felt it was too late, her oppression was entrenched in that environment. Both left eventually their employment.

These are two cases I know of, and I wonder how many other Indigenous psychologists have suffered racism in silence, who may have internalised this and felt that they personally were somehow lacking rather than seeing it as the forces of individual, institutionalised and cultural racism. The impact of racism on its victims and the danger that victims believe this oppression is justified or deserved in some way is my greatest concern.

Times have changed and our discipline has changed. The groundswell of what we have called the Indigenous mental health movement was, in a sense, part of a greater positive social change that happened for Indigenous Australia in the late 1980s, early 1990s.

Often we remain silent and don't share our experiences of racism because sometimes stories are unspeakable and threaten the core of our dignity. When I wrote my doctorate and described my grandmother's life and times, I outlined how she never spoke about the considerable oppressions she faced. I concluded that perhaps it was impossible to speak the unspeakable and perhaps she thought speaking it would make others think that she was somehow deserving of the demeaning treatment meted out to her across her life. As Aboriginal academic, Jackie Huggins wrote,

> *My mother does not want to talk even to me about the kinds of bitter treatment she experienced. What stops her from speaking is the same thing that stops other people speaking about the profound suffering they have experienced. The oppression and pain can be so fierce as to make people mute. They carry this experience inside themselves.... Guilt and shame are manifest in women who have suffered this and there is a self-blaming that makes them see their situations as their fault or the fault of their race (1994, p36).*

Jones' (1997) conclusions about the impacts of racism are relevant to Indigenous Australian People. He states that firstly, racism is a lived experience; it is real and happens in many ways. Secondly, racism not only hurts at the time it happens, but has a cumulative effect. These become part of the narrative of the community in an 'us and them' perspective. Racism at different levels might be seen as a natural part of life. Thirdly, repeated experiences of racism affect a person's behaviour and understanding of life; one's life expectations, perceptions of oneself and ones' groups and the dominant group and many ways of coping with racism contribute to the psychological reality of people of colour. Living with racism can become a central and defining element in the psychology of marginalised and/or people of colour.

In many ways, life is a struggle for people of colour. Even for those who have 'made it' and have overcome obstacles to achieve a meaningful life, different forms of racism need to be confronted; it is inescapable.

Changes in Mental Health and Indigenous People

What does all this mean to our discipline of psychology?

Psychologists belong to a profession that has historically been conservative and identified with the dominant Anglo-based and Western European cultural traditions of Australia. Like

other institutions, psychology has a history of excluding those from different cultures. In fact some would say they been complicit in the disenfranchisement of the marginalised and that they need to examine their role within the social and political structures and systems that give rise to, and perpetuate, racism.

There is a group of us who have been working in the area of Indigenous mental health for many years. When we initially came together as a group, there was little attention to Indigenous issues in Australian psychology. In 1991 when we set up the *APS Interest Group Aboriginal People Issues and Psychology*, imperatives such as social justice and self-determination were quite unusual discourses in psychology. Since the formation of the group, when we were always peripheral, we are now a strong part of the Australian Psychological Society (APS).

The 1995 APS Annual Conference in Perth Western Australia attracted an unprecedented Indigenous presence. For the first time there was an Aboriginal welcome to the country and the first ever Indigenous keynote presentation. Rob Riley, one of our most outstanding Aboriginal statesmen and social justice activists and was the first ever Indigenous keynote at an APS Annual conference. He was part of the stolen generations and as well as influencing the development of native title agreements he instigated the *Bringing Them Home* Reports. Rob took his life less than a year afterwards in 1996. The unresolved grief of his personal experiences and the never-ending challenges in the struggle for social justice wore him down.

I am proud that Rob Riley delivered our first Indigenous keynote. I am ashamed of our discipline that the space was so hard to win. I am resentful in retrospect that this keynote took place on the side of the main program; it was not well attended and the senior people of our profession did not bother to attend. I am proud that although he was suffering at the time from acute stress, emotional distress and fatigue, Rob prepared and delivered an important, historical and now widely demanded paper, hoping that in some way it would make a difference. He charged us, psychology, with this responsibility:

> *How many psychologists have an understanding of Aboriginal people? How many of you … have an understanding of Aboriginal culture, history and contemporary issues. For many of you, this work is crucial given the social conditions and your work environment in such places as prisons and the welfare sector and where there are large numbers of Aboriginal clients. It is your responsibility to seek that knowledge and understanding now, and to ensure that it is available for future generations of psychologists, in psychological training and education programs. (Riley, 1997, p. 15-16)*

Have things really changed very much?

In the 1960s black psychiatrist, Frantz Fanon wrote:

> *… but the first encounter with the white man oppresses him with the whole weight of his blackness. (Fanon, p. 150)*

Fanon believed that most mental illness and psychopathology in the oppressed was the product of a colonised situation, that is, that black people's neuroses stemmed from contact with the white world, with racism, and further that the institutions for mental health have only sought to 'cure' the native so he will accept being part of the social background of the colonial type:

> *Because it is a systematic negation of the other person and a furious determination to deny the other person all attributes of humanity, colonialism forces the people it dominates to ask themselves the question constantly: "In reality, who am I?"(ibid)*

Times have changed and our discipline has changed. The groundswell of what we have called the Indigenous mental health movement was, in a sense, part of a greater positive social change that happened for Indigenous Australia in the late 1980s, early 1990s.

One of the most significant events affecting Indigenous mental health was the *Ways Forward* Report (Swan & Raphael, 1995). And we were a part of this. We and other scholars in Indigenous mental health defined the historical period of this consultancy and report about Aboriginal and Torres Strait Islander mental health; a collaboration between non-Indigenous and Indigenous people in the field and a landmark event symbolising a different focus. Indigenous politically and culturally informed constructions of health and mental health began to emerge. Changes came about in perceptions of Indigenous mental health. Rather than the 'disease model' perspective there was a prioritising of wellness, holistic health, and culturally informed and appropriate approaches. For me, a most important element was that this process had included Aboriginal people in an unprecedented way.

These changes in perceptions toward Indigenous mental health were underpinned by key elements that included a philosophical approach of empowerment and self-determination in the provision of mental health services for Indigenous people. Services that worked with Indigenous people needed to ensure that mechanisms were in place for collaboration and direction from the client groups. Indigenous people

needed to be fully involved in any mental health activity for Indigenous people. Indigenous people themselves needed to direct the engagement, at all levels, whether this was an interaction between a psychologist and a client, or establishing services and developing policy.

To conclude with a personal vision … If we don't change, if we don't own the racism in our country and professions, we cannot begin the change we need for a just, equal and well society that we can all share.

Mental Health and Emotional Social Wellbeing

Mental health problems and mental illness refers to 'the range of cognitive, emotional and behavioural disorders that interfere with the lives and productivity of people' (AHM 2003:5). A mental illness is a clinically diagnosable disorder that significantly interferes with an individual's cognitive, emotional or social abilities. Traditionally, the concept of mental health comes from an illness or clinical perspective and focuses more on the individual and their level of functioning in their environment.

An Australian Aboriginal view of mental health relies on a concept of social and emotional wellbeing which recognises that achieving optimal conditions for health and wellbeing requires a holistic and whole-of-life view of health that encompasses the social, emotional and cultural wellbeing of the whole community (SHRG 2004). A holistic view of health had been voiced by Aboriginal people in numerous reports in and was developed further in Swan and Raphael's *Ways Forward* (1995):

> *Aboriginal concepts of mental health are holistic and are defined as follows: Health does not just mean the physical well-being of the individual but refers to the social, emotional and cultural well-being of the whole community. This is a whole of life view and includes the cyclical concept of life-death-life. Health care services should strive to achieve the state where every individual can achieve their full potential as human beings and thus bring about the total wellbeing of their communities. (1995, p20)*

Social and emotional wellbeing problems cover a broad range of problems that can result from unresolved grief and loss, trauma and abuse, domestic violence, removal from family, substance misuse, family breakdown, cultural dislocation, racism and discrimination, and social disadvantage (SHRG 2004). As a concept encompassing this holistic view of health, social and emotional wellbeing also seeks to recognise Aboriginal and Torres Strait Islander people's particular experiences of grief and trauma through colonisation, separation from families and loss of land and culture.

Psychologists have gradually acknowledged this changed perspective. Many challenges remain and Indigenous researchers continue to call for appropriate inclusion of Indigenous people. Hunter a well-known psychiatrist wrote in 1997:

> *'Self Determination', 'quality of life', 'well being'… these are terms that have only recently entered the vocabulary of mental health professionals working in Indigenous settings. They are unfamiliar and handled with uncertainty and at times temerity. But they are also unavoidable. (Hunter, 1997, p. 6)*

Conclusion

This paper has located Australian Indigenous mental health within its historical and cultural context and background of colonisation and racism. The paper has argued for a broader approach to Indigenous mental health that recognises a social and emotional wellbeing model rather than a more clinically based one. The paper has highlighted and applauded significant changes occurring in the way Indigenous mental health is conceptualised; changes that it suggests auger well for the future.

To conclude with a personal vision … If we don't change, if we don't own the racism in our country and professions, we cannot begin the change we need for a just, equal and well society that we can all share. The following message of hope is from Dr Joan Winch, a Nyoongar Elder:

So the struggle will continue, but we will not be alone, other Australians will be by our side, and together we will make a difference.

The most profound change has to happen in the hearts of those who wish to help. I believe that we can walk into the future together and build a country where cultural diversity is respected and celebrated, where the future for our children can be very different and positive from the past of our parents and grandparents. (Professor Joan Winch, Nyoongar Elder, The Last Word, 2000)

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Processes of Change in Dialectical Behavior Therapy

Alan E. Fruzzetti and Julie M. Skutch

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Dialectical Behavior Therapy (DBT) is a comprehensive, multi-modal treatment developed for complex, multiply-disordered clients with pervasive problems in emotion regulation (Linehan, 1993a; 1993b). DBT conceptualizes suicide attempts, self-harm, and other out-of-control behaviors as attempted solutions (albeit problematic ones) to severe emotion dysregulation, and targets these problems using a combination of both acceptance- and change-oriented strategies and interventions, helping patients learn a wide range of skills related to self-control, awareness, emotion regulation and good relationships.

Originally developed for chronically suicidal and self-harming women, DBT more recently has been applied successfully to other problems related to emotion dysregulation (eating disorders, substance use disorders, severe interpersonal problems, and so on), and has been successfully implemented in outpatient, inpatient, residential, day-treatment, emergency, and forensic settings, with both adolescents and adults. DBT is the standard of care for Borderline Personality Disorder (BPD), which is considered the prototype of emotion dysregulation disorders, with considerable data to support its use with these populations. Both randomized control trial data and other studies have shown DBT to produce significant reductions in suicidal ideation, non-suicidal self-injurious behavior, depression, substance use, eating disordered behaviors, anger, and so on, as well as improved relationships and overall life functioning, with gains largely maintained at follow-up (cf. Feigenbaum, 2006; Robins & Chapman, 2007; Koerner & Dimeff, 2000 for reviews). More recently, DBT has been extended to treat clients with BPD and comorbid PTSD with promising results (Harned, Korslund, Foa, & Linehan, 2012), eating disorders (Chen, et al., 2009), as well as women victims of domestic violence (Iverson, Shenk, &