European Dialectical Behaviour Therapy Association

NEWSLETTER

#3 December 2024

www.edbta.eu

We are first an enormous network and then individual meshes. The future of our species lies in this experience. It will lead us out of the egocentrism in which we harm each other and bring us a new understanding of our humanity
Willigis Jaeger

Willigis Jaeger, the source of this quote, was Marsha Linehan's Zen teacher. He was a German Catholic priest, a Benedictine monk, and a Zen master who trained and taught in the Sanbo Kyodan tradition.

In a sense, we can call him the philosophical backbone of DBT.
Catholic authorities questioned his teaching, and he was banned from teaching in public events and in writing in 2002. He was 78 years old and on his own when he decided to defy the Catholic Church and leave his abbey to start over to continue his work.
In this sense, we can call him a powerful and confident backbone of DBT.

In 2003, he founded the Benediktushof, an inter-religious center of meditation and awareness, where he lived and taught. The Benediktushof became a spiritual home for a wide-ranging community of people who, in very different ways and for very different reasons, did the same thing: practicing mindfulness and trying to make the world a better place.
In this sense, he embodies the spirit of DBT.

Marsha, his student, embodied all these virtues and created DBT, an opus, that not only aims to alleviate the suffering of our patients, but also enables us all to practice applied spirituality. Each of us in their own way, especially now.

Prof. Martin Bohus, MD
President EDBTA

DECEMBER NEWS

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CALL FOR ABSTRACTS AND REGISTRATION FOR THE 1ST EUROPEAN DBT CONGRESS

The European DBT Association (EDBTA), in collaboration with the Polish Association for DBT (PTDBT), is pleased to remind you about the upcoming 1st European DBT Congress, taking place on May 8–10, 2025, in the historic city of Gdańsk, Poland. This landmark event will bring together the DBT community from across Europe and beyond for an enriching program of seminars, workshops, and networking opportunities, all set within the warm and welcoming atmosphere of Poland. The Congress offers an affordable, hybrid format, ensuring accessibility for all participants, whether attending in person or virtually.

The abstract submission deadline has been extended to January 5th, 2024

Don't miss your chance to contribute! We welcome abstracts for oral presentations, posters, and workshops that highlight innovative DBT research, clinical applications, and advancements.

Registration for congress opens January 1st, 2025
Be sure to secure your spot early and take advantage of early bird rates starting on the New Year!

Why Attend?

- Gain insights from global leaders in DBT.
- Participate in engaging workshops and presentations tailored to clinical and research advancements.
- Network with peers and professionals to share knowledge and collaborate.

For abstract submission guidelines, registration details, and the latest updates, visit the official Congress website (link).

Don’t miss this opportunity to join the European DBT community in shaping the future of DBT practice and research. We look forward to welcoming you to Gdańsk!

DECEMBER NEWS

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START THE NEW YEAR WITH MINDFULNESS IN DBT

5th of January, 7 p.m. CET, live stream on EDBTA youtube and at edbta.eu/live

In this upcoming webinar, Jan Glasenapp will share his rich and integrated knowledge and experience of mindfulness nourished by Zen Buddhism, Chinese Chan practices and modern psychotherapy such as DBT.
As he writes in his essay from 2018 (*), "mindfulness in the intersection of spirituality and psychotherapy can support people in their dealings with suffering in many ways, for example through:

- the observation of opportunities to strengthen compassion for oneself and others and to strengthen prosocial behavior;
- the expansion of the ability to concentrate on different sensations;
- the expansion of the ability to not only perceive these impressions, but also to accept them in their never-ending variability;
- the observation of mental activity, thoughts and feelings without binding to or adhering to them;
- the deconstruction of the identity building constructions with regard to their contribution to suffering, especially in terms of responsibility, own actions, help of others and death;
- the promotion of intuition in decision-making;
- the awakening of wisdom as a mentally calm and open state, in which the internal and external struggles for demarcation are ended [...]."

Meet the facilitator **PhD Jan Glasenapp!**

Jan finished his studies in psychology at the University of Bielefeld in 1997 with distinction. He completed several post-graduate trainings in psychotherapy, including Client-centered Therapy, Transaction Analysis and Cognitive Behavioral Therapy. In 2001, he got certified as a psychological psychotherapist and started working in private practice in Berlin and later in Schwäbisch Gmünd. Since 2003 to present, he has served as a teaching therapist and supervisor at several academies for postgraduate psychotherapy studies. He is also a consultant and supervisor for several mental health care institutions. In 2011, he acquired a specialization in DBT and 2014 in Mindfulness in psychotherapy by Prof. Marsha Linehan. From 2016 on, he has been a teaching therapist of Zhong-De-Ban and did many trainings in China, including a systematic CBT-training for the GuangDong Psychological Association. He serves as supervisor for the Nanjing Brain Hospital. 2022 he became appointed guest professor of School of Psychology, SCNU, Guangzhou, in 2024 associate professor at Nanjing Medical University and visiting professor at Jiao Tong University, Shanghai. He works on the improvement of modern psychotherapy interventions by integration of mindfulness.

**Mindfulness between West and East. An approach to spirituality in psychotherapy with Dialectical-Behavioral Therapy (DBT) and Chan. 2018. Georg Juckel, Knut Hoffmann & Harald Walach (Ed.). Spiritualität in Psychiatrie & Psychotherapie (S. 211-236). Lengerich: Pabst.*

DECEMBER NEWS

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CONFERENCE HIGHLIGHTS

10th Annual Society For Dialectical Behaviour Therapy in UK and Ireland

SfDBT in UK and Ireland 10th Annual Conference and Workshop 3rd and 4th of October 2024, themed "Adapting DBT for Neurodiversity" was attended by 350 people, 200 of whom attended the post conference workshop. Professor Luisa Weiner, delivered the first keynote address entitled Neurodiversity, BPD, and DBT: research findings and clinical applications. The second keynote address, entitled Leveling up Dialectical Behaviour Therapy for Autistic Individuals with Emotion Dysregulation was coproduced between Professor Matthew Lerner and Dr Elliot Keenan, who is amongst many other things an expert by experience in the use of DBT for people with neurodiversity issues. The conference also offered attendees parallel workshops on aspects of DBT delivery. The SfDBT also said goodbye to its founding President Professor Michaela Swales and inaugurated its new president Dr. Emily Fox. Fellowships were offered to Emily Fox and Daniel Flynn for their work for the SfDBT. Two post conference workshops, one by Sonny Jane Wise and one by Dr Lorie Ritschel further highlighted practical steps for working with clients with neurodiversity. Take home points from the two days included an emphasis on tailoring the treatment to the client you have in front of you and also to treat alexithymia as proactively as possible. Feedback from conference and workshop attendees was overwhelmingly positive.

DECEMBER NEWS

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ASSISTED DYING LEGISLATION - A NOTE ON RECENT EXPERIENCES AT THE PALACE OF WESTMINSTER

Lars Mehlum MD PhD

Over the last few years an increasing number of countries in Europe and other parts of the world have legalized physician assisted suicide and euthanasia, collectively referred to as assisted dying. By this, legislators typically have aimed to allow people who are terminally ill and/or have hopeless medical conditions from which they experience what is perceived as intractable pain and unbearable suffering. In reality, however, experience from countries such as Belgium and the Netherlands, show that assisted dying is not only granted to people with terminal physical illness; people with mental illness have gradually also been considered eligible. In 2020 we reviewed the published research on assisted dying received by people with personality disorders (Mehlum et al, 2020) and concluded that the current legislation and practice of assisted dying for this group lacks a basis of adequate understanding their underlying psychopathology. Furthermore, both legislators and physicians involved in assisted dying seem to lack awareness about the contemporary treatment literature for people with personality disorders resulting in a practice neglecting the individual patient's potential for having a life worth living.

The last country to initiate a change in this type of legislation is the United Kingdom; this became clear through a so-called Private Member's Bill recently proposed in the British Parliament by Labour's MP Kim Leadbeater. Fearing the same developments in the UK as have been witnessed in other countries, representatives from mental health advocacy organizations teaming up with leading experts in palliative medicine and C-L psychiatry in the UK helped organize a meeting November 19th for MPs in the House of Commons chaired by James Frith MP from the Labour party. I was invited to speak at this meeting since I am one of relatively few who have published scientifically on the matter of assisted dying amongst people with personality disorders. I pointed out that many politicians - and clinicians - lack adequate insight into the psychological processes often involved when people become suicidal. In particular they underestimate the sense of entrapment very often experienced by those who are suicidal. This is an extremely painful and burdensome experience, but at the same time treatable with the help of evidence based interventions. The points I made were well taken and I believe that the ensuing discussion was enlightening for us all.

After the parliamentary hearing, the proposed bill went on to a vote in the House of Commons on November 29th, and it actually passed with a wider margin than expected; 330 to 275. Although a lot of parliamentary processes will now be undertaken, the principle of the bill in legalizing assisted dying will probably not be challenged. Thus, it seems that the UK is now in the process of making dramatic changes in their legislation in this important area without careful legislative preparations that could have laid a much firmer foundation for an informed political decision on assisted dying.

For us as a community of therapists caring for a community of patients, the recent developments should give rise to serious concern. I would hope that we all will stay vigilant and informed and ready to provide the public and legislators with what we have to offer of knowledge and experience to promote more informed political decisions.

Literature: *Mehlum L et al. Euthanasia and assisted suicide in patients with personality disorders: a review of current practice and challenges.Borderline Personal Disord Emot Dysregul.***,** *2020; 7:15.*

COUNTRY INTRODUCTIONS

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Lithuania

The first DBT skills group in Lithuania was financed by the local Rotary Club in Vilnius (2017). Over many years Lithuania has been one of the unfortunate leaders of international suicide statistics. Tragic for the country this has helped generate public and political support for DBT, the method has been included in the national guidelines as a specialized treatment for individuals at high chronic suicide risk. Nevertheless the development of DBT here is still in its toddler stage. We were able to take our first steps thanks to the generous support of Professor Ulrich Schweiger from Lübeck University, who conducted several trainings. In the capital Vilnius DBT gained true momentum when we had several teams trained intensively by Michaela Swales, Christine Dunkley and Amy Gaglia (2018). Amy has been a reliable supporter and supervisor for several of our young teams in Vilnius ever since. We are happy to have three programmes funded by state health insurance, however our community of therapists is not well organized yet and DBT is not available in other regions of the country. DBT is however kicking off in the prison system at the moment. All complex DBT programmes can be seen at www.dbt.lt (only in Lithuanian language).

ASSOCIATION IN PROGRESS

We do not have a national DBT association yet, we are however in the process of founding it. This means there is also no formal leader yet. However members of the different teams are involved in common projects (organizing trainings, supervision and the DBT website).

Active local therapy programmes

- DBT individual and skills group at a psychosocial rehabilitation centre in the central district of Vilnius (3 months, day hospital);
- Crisis centre in the central district of Vilnius offering DBT as a follow up treatment after an intense crisis intervention (individual and group, 3 months, day hospital);
- Psychiatric day hospital at the edge of Vilnius (individual and group, 3 months, day hospital)

How is training organized?

Since we do not have certified trainers in Lithuania at the moment, we mostly rely on international training. This is cost intensive and reduces accessibility for professionals with limited knowledge of foreign languages.

Plans for the future

Our priority at the moment is the establishment of a national association, the EDBTA has been a great encouragement to us in this process. We want to have several local trainers who could help to maintain existing programmes and spread DBT further into the country. In cooperation with the Ministry of Health we are working on acquiring funding for a next round of training teams outside of Vilnius.

COUNTRY INTRODUCTIONS

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Lithuania

Current challenges

- Training more therapists and building up teams in other towns and cities. No services for adolescents yet.
- Founding a national DBT association: Many professionals have two or three jobs and families to take care of, which leaves little time for voluntary work.
- Brain drain of professionals to private mental health services.

How do you involve people with lived experience?

A cooperation with the NGO “Artyn”, which represents the interests of people with BPD, has been established (seminars, discussions, educational projects).

What can we give to others and what do we need from others?

During the process of setting up a solid local DBT infrastructure we will need international support with training, supervision and administrative advice. In the future, we will need expertise establishing DBT for adolescents. We are happy to share our very limited experience with anyone who is interested.

Representative at the EDBTA:

Jan Hilbig
Psychiatrist, psychotherapist

COUNTRY INTRODUCTIONS

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Norway

The story of DBT implementation in Norway started from no less than a need to establish evidence-based interventions to prevent youth suicide. In 2006 no such interventions were available, however, several smaller and uncontrolled trials had given reasonable hopes that DBT-A, developed by Alec Miller and Jill Rathus, could be efficacious. A research group at the University of Oslo, led by Professor Lars Mehlum therefore conducted the first randomized trial of DBT-A showing that DBT-A led to strongly reduced numbers of self-harm (suicidal and non-suicidal self-harm) episodes at end-of treatment and at 1 and 3 years follow-ups, also showing that this treatment actually is a highly cost-effective treatment. At this time there were no DBT therapists available in Norway, thus the research group started what eventually became the national DBT training program. The new research and the treatment program made many clinicians interested in learning about DBT. People felt that it was important not only to import a treatment method from abroad but also to actively build the evidence base within a Norwegian context. This idea, that treatment, training and research should be linked together, was one of Marsha's original and extremely important ideas. In Norway, we have, thus, established a clinical research network of collaborating DBT-units collecting data with the same protocol using the same data harvesting facilities. Every hospital trust in Norway has teams trained in DBT, meaning that there is reasonably good access to DBT. Importantly implementing DBT strongly relies on a strong network of peers locally and nationally and this is cultivated through biennial national DBT-conferences (commonly named “the DBT festival”) organized by the DBT-training program in collaboration with local groups and with the national association for DBT (N-DBT).

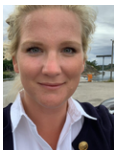
163 MEMBERS

Norwegian Association for Dialectical Behavior Therapy (N-DBT) is a non-profit organization founded in 2017, which aims to increase knowledge, use, and respect for DBT as a treatment method in Norway, among both clinicians, clinical directors, politicians, clients and their relatives, and the public.
N-DBT aims to contribute to increase collaboration between clinicians and clinics using DBT both in Norway and other countries, and we aim to support the important work carried out by the researchers and trainers at the National Centre for Suicide Research and Prevention at the University of Oslo. We work to support further development, innovation, and research regarding DBT as a treatment method in Norway.

How is training organised?

Training of therapists and trainers is provided by the DBT Training Program at The National Centre for Suicide Research and Prevention, University of Oslo. Established in 2006, a tier 1 affiliate of B.Tech, and has trained over 600 clinicians organized in over 50 DBT teams. Six trainers and two additional supervisors are all providing monthly consultation to nearly thirty established teams. The program is led by Associate Professor/DBT trainer Anita J. Tørmoen and offers intensive and foundational trainings, all in line with established course descriptions from B. Tech. Prerequisites: clinical psychologists, psychiatrist, or other mental healthcare professionals with a master’s degree. At least 50% of the team should be psychiatrists or clinical psychologists.

Who is in charge?



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COUNTRY INTRODUCTIONS

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Norway

Current challenges

- DBT for people with autism spectrum disorders. It can be a challenge for therapists to work effectively with self-harming neurodivergent patients, so there is a great need for structured adjustments of the standard program, and research to support the developments.
- Sufficient treatment to children and adolescents under the care of the Norwegian child welfare services (CWS)– a particularly vulnerable group that is known to have serious psychological problems, but due to systemic issues has been challenging to treat. The DBT-OEM (Omsorgs og Endringsmodellen; Care and Development Model) is an ongoing project whose purpose is to bridge the gap between CWS and psychiatric care. Fully trained DBT-therapists work closely with milieu staff trained in a DBT informed method in a residential care setting. The target group is adolescents between the age 12-18 struggling with emotion regulation and are under the care of the Norwegian CWS.

Plans for the future

N-DBT strives to establish a network of skilled DBT-therapists nationwide, who can exchange practical solutions, exciting new developments and novel materials. We also acknowledge the importance of the role of team leaders, and therefore focus on providing them with extra support and training. Norway has many exciting ongoing projects - some of which are already implemented, while others are being researched and evaluated continuously - these include DBT-OEM, DBT-C, DBT-PTSD, and DBT-SUD in combination with Narrative Exposure therapy. Our focus is to facilitate the future development and research of DBT for different patient populations, while addressing different aspects of the standard method. And last but not least, we are very proud of the recently published study by Professor Lars Mehlum and his colleagues, who conducted an RCT with a long-term follow-up of adolescents with repeated deliberate self-harm and borderline characteristics. Assessments included both structured interviews and self-report at baseline and 1.6, 3.1 and 12.4 years follow-up, in addition to a qualitative interview at 12.4 years. Results published so far show that early remission of self-harm predicts emotional regulation capacity in adulthood.

Active local therapy programmes

DBT is now provided in every health region in Norway, by around 50 DBT-teams. The teams offer among other programmes 1) standard DBT for adults – from 6 months up to two years, plus next phase focusing on trauma therapy, or working on other areas for a live worth living such as cognitive restructuring 2) DBT-A for adolescents. Most teams run a 16- 24 week program, after the modification of Miller and Rathus. 3) DBT for children (DBT-C), the modification of Dr. Francheska Pereplechikova, is currently established in five clinics, and rising. DBT-C is developed to treat children with severe emotional dysregulation, by adressing the harmful transactions between caregivers and child, emphasizing the adult's responsibility. DBT-C uses the same theoretical model and treatment principles as in standard DBT, but is modified to fit the cognitive skills and lesser power of the 7-12 years old child.

N-DBT
Norsk forening for dialektisk atferdsterapi

Advice for others

Good implementations strategies are of essence! DBT is an organization based treatment, effective but also demanding. Having leaders who have adequate understanding of the method is important. N-DBT searches to be of help by collecting and providing good examples of how quality DBT can be organized to inspire teams all over the country.

What can we give to others and what do we need from others?

We would like to build a common arena to support each other, share experiences, collaborate on research, and development in DBT. We in Norway are lucky to have a large DBT community and we could contribute with experience, support and collaboration.

RESEARCH DIGEST

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Online dialectical behavior therapy for binge eating disorder: an open trial

Maria Karapatsia, Chara Tzavara, Ioannis Michopoulos & Fragiskos Gonidakis, Eating Disorders, https://doi.org/10.1080/10640266.2024.2421047

EATING DISORDERS
https://doi.org/10.1080/10640266.2024.2421047

Routledge
Taylor & Francis Group

Online dialectical behavior therapy for binge eating disorder: an open trial

Maria Karapatsia[a], Chara Tzavara[a], Ioannis Michopoulos[b], and Fragiskos Gonidakis[a]

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ABSTRACT

The purpose of the present study was to examine the efficacy of online Dialectical Behavior Therapy for Binge Eating Disorder (DBT-BED) in reducing eating psychopathology and investigate the factors that influence the severity and frequency of binge eating. Seventy-three individuals seeking treatment for BED participated in 20 two-hour group sessions. Participants completed the Emotional Eating Scale (EES), Binge Eating Scale (BES), and Eating Disorder Examination Questionnaire (EDE-Q) before and after the treatment and at three- and six-month follow-ups. Results from 58 participants were analyzed. The study results indicated a significant decrease in objective binge eating (OBE) days, as well as in all EES, BES, and EDE-Q subscales (except the Restraint subscale), and global EDE-Q score at the end of treatment and follow-ups. Moreover, the Body Mass Index (BMI) reduced at the end of treatment and during the follow-up period. Except for the Restraint subscale, more OBE days were linked with higher EES, BES, and EDE-Q scores. Overall, the study suggests that online DBT-BED is an effective approach to treating Binge Eating Disorder (BED) for individuals who cannot receive in-person therapy. Further research is necessary to compare the efficacy of online DBT-BED with other interventions.

Clinical Implications

- Emotion dysregulation is linked to binges.
- Online DBT-BED is a promising treatment.
- Online DBT-BED effectively reduces binge eating urges after negative emotions.
- In addition to binge eating, online DBT-BED can also decrease general eating psychopathology.

Introduction

The authors of this study examined the effects of an online group programme of Dialectical behaviour therapy for Binge eating disorder (DBT-BED). In total 58 participants (93.1% were females, mean age was 44 years) completed the series of evaluations stretching from onset to a follow-up 6 months after completion of the group. On average participants participated in 18.6 group sessions which covered mindfulness, distress tolerance and emotion regulation skills based on a DBT-BED manual developed by Safer and colleagues (2009). In this programme participants are also taught how to analyze their eating behaviour and apply skills to stop binging. According to the authors, no other study had examined the effects of an online DBT intervention for Binge eating disorder. There was no control group.

Key findings

- A significant reduction in objective binge eating days was observed and could be maintained including follow-up 6 months later.
- Scores on the Binge eating severity scale (BES) and general eating psychopathology measured by the Eating Disorder Examination Questionnaire (EDE-Q 6.0) also decreased significantly.
- Improvements in emotion regulation measured by the Emotional eating scale (EES) correlated with dynamics observed in Binge eating severity (BES).
- There was a small but significant reduction in BMI (-1,15).
- Although there was no control group, the authors suggest the changes observed could be interpreted as being related to the intervention: The average onset of the disorder was 19.9 years and thus participants (mean age 44 years) had already been suffering for a significant part of their lives reducing the likelihood of a spontaneous change of this magnitude.

RESEARCH DIGEST

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Early remission of deliberate self-harm predicts emotion regulation capacity in adulthood: 12.4 years follow-up of a randomized controlled trial of adolescents with repeated self-harm and borderline features

KIselin Solerød Dibaj, Anita Johanna Tørmoen, Ole Klungsøyr, Katharina Teresa Enehaug Morken, Egil Haga, Kine Johansen Dymbe & Lars Mehlum
European Child & Adolescent Psychiatry (2024)
doi: 10.1007/s00787-024-02602-8

This Study

This longitudinal follow-up study examined the impact of early remission from deliberate self-harm (DSH) on emotion dysregulation (ED) in adulthood. Conducted in Norway, the research followed 77 adolescents (aged 12–18 years) with borderline personality features and repeated DSH over a span of 12.4 years. Participants were part of a randomized controlled trial (RCT) comparing Dialectical Behavior Therapy for Adolescents (DBT-A) with enhanced usual care (EUC).

Assessments were conducted at baseline, 1.6 years, 3.1 years, and 12.4 years post-treatment. Measures included: DSH remission defined as one year without any DSH episodes, emotion dysregulation (ED), measured using the 16-item Difficulties in Emotion Regulation Scale (DERS-16) and coping strategies, evaluated through the DBT Ways of Coping Checklist (DBT-WCCL). The study sought to determine whether early DSH remission influenced long-term ED and whether changes in coping strategies mediated this effect.

Key Findings

- Adolescents achieving DSH remission within one year of treatment showed significantly lower ED levels in adulthood. Direct effects of remission on ED were stronger for participants in the EUC group (β = -24.00, p = 0.02) compared to DBT-A participants (β = -14.56, p = 0.08). It should be noted that in the DBT-A group, the overall level of DSH was already lower, so the difference between achieving remission (no DSH) and not was less significant compared to the EUC group. In the EUC group, more participants had ongoing, repeated DSH, making the contrast between remission and continued self-harm more pronounced.
- Both groups improved their functional coping skills over time, but only the DBT-A group showed significant reductions in dysfunctional coping behaviors (e.g., blaming others and non-acceptance), which were strongly associated with adult ED.
- The impact of early DSH remission on ED was not mediated by changes in dysfunctional coping, suggesting a direct effect of behavioral change in reducing long-term ED risks.
- Participants with a history of physical abuse reported higher adult ED, emphasizing trauma's impact on long-term emotional health.

Recommendations

- Early cessation of DSH should be a primary goal in adolescent treatment, as it has long-term implications for reducing ED in adulthood.
- DBT-A's strengths in reducing dysfunctional coping and supporting behavioral change make it a valuable intervention for high-risk adolescents.
- Treatment plans should explicitly target maladaptive coping behaviors, such as blaming others or self-criticism, while addressing trauma to support emotional regulation development.

RESEARCH DIGEST

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An Umbrella Review of Cognitive Behavioural and Dialectical Behavioural Therapies to Treat Self-Harm and Suicidal Behaviour in Adolescents.


Systematic Review

An Umbrella Review of Cognitive Behavioural and Dialectical Behavioural Therapies to Treat Self-Harm and Suicidal Behaviour in Adolescents

Abstract

Keywords

Introduction

Carla Torralba-Suarez , Antonio Olry-de-Labry-Lima
Actas Españolas de Psiquiatría (2024)
doi: 10.62641/aep.v52i4.1631

This study:
This umbrella review compiled findings from nine systematic reviews on the effectiveness of Cognitive Behavioral Therapy (CBT) and Dialectical Behavioral Therapy (DBT) for adolescents aged 13–18 with self-harm or suicidal behaviors. Data was collected from databases including PubMed, Cochrane Library, and PsycINFO, focusing on studies published between 2012 and 2022. The reviews assessed the impact of these therapies on outcomes such as suicidal ideation, self-harm, and suicidal behaviors, using standardized measures like odds ratios (OR) and standardized mean differences (SMD).

Key Findings

- Standalone CBT had mixed results, with limited evidence of reducing self-harm or suicidal ideation compared to treatment as usual (TAU). Combined CBT and fluoxetine seems to be more effective in reducing suicidal behaviors in adolescents with depression (e.g., OR = 0.26, 95% CI: 0.09–0.72).
- DBT significantly reduced self-harm (OR = 0.28, 95% CI: 0.12–0.64) and suicidal ideation (SMD = -0.71, 95% CI: -1.19 to -0.23), showing consistent benefits compared to TAU and was particularly effective for adolescents with repeated self-harming behaviors or mood disorders.
- The study had several limitations. Included reviews had high heterogeneity. Variation in study designs, interventions, and populations affected comparability. Most systematic reviews included were rated as low or critically low quality and many therapies researched were adapted from adult treatments, limiting their relevance to adolescents.

Recommendations

- DBT consistently shows strong evidence for reducing self-harm and suicidal ideation and should be a primary intervention for high-risk adolescents.
- Combined CBT and pharmacotherapy (e.g., fluoxetine) can enhance outcomes but requires close monitoring due to the increased risk of suicidal ideation with some antidepressants.
- More robust RCTs in both therapy formats should be conducted to allow for a direct comparison of effectiveness between CBT and DBT, evaluate group vs. individual therapy formats, and investigate their long-term impact.

RESEARCH DIGEST

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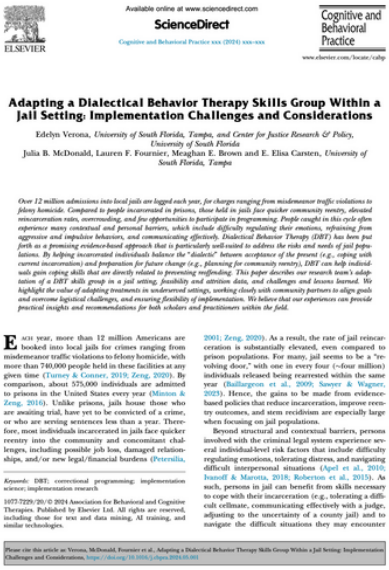
Adapting a Dialectical Behavior Therapy Skills Group Within a Jail Setting: Implementation Challenges and Considerations

Edelyn Verona, Julia B. McDonald, Lauren F. Fournier, Meaghan E. Brown, E. Elisa Carsten
Cognitive and Behavioral Practice (2024)
doi:10.1016/j.cbpra.2024.05.001



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Cognitive and Behavioral Practice xxx (2024) xxx–xxx
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Adapting a Dialectical Behavior Therapy Skills Group Within a Jail Setting: Implementation Challenges and Considerations

Edelyn Verona, *University of South Florida, Tampa, and Center for Justice Research & Policy, University of South Florida*
Julia B. McDonald, Lauren F. Fournier, Meaghan E. Brown and E. Elisa Carsten, *University of South Florida, Tampa*

Over 12 million admissions into local jails are logged each year, for charges ranging from misdemeanor traffic violations to felony homicide. Compared to people incarcerated in prisons, those held in jails face quicker community reentry, elevated reincarceration rates, overcrowding, and few opportunities to participate in programming. People caught in this cycle often experience many contextual and personal barriers, which include difficulty regulating their emotions, refraining from aggressive and impulsive behaviors, and communicating effectively. Dialectical Behavior Therapy (DBT) has been put forth as a promising evidence-based approach that is particularly well-suited to address the risks and needs of jail populations. By helping incarcerated individuals balance the "dialectic" between acceptance of the present (e.g., coping with current incarceration) and preparation for future change (e.g., planning for community reentry), DBT can help individuals gain coping skills that are directly related to preventing reoffending. This paper describes our research team's adaptation of a DBT skills group in a jail setting, feasibility and attrition data, and challenges and lessons learned. We highlight the value of adapting treatments in underserved settings, working closely with community partners to align goals and overcome logistical challenges, and ensuring flexibility of implementation. We believe that our experiences can provide practical insights and recommendations for both scholars and practitioners within the field.

Each year, more than 12 million Americans are booked into local jails for crimes ranging from misdemeanor traffic violations to felony homicide, with more than 740,000 people held in these facilities at any given time (Turney & Conner, 2019; Zeng, 2020). By comparison, about 575,000 individuals are admitted to prisons in the United States every year (Minton & Zeng, 2016). Unlike prisons, jails house those who are awaiting trial, have yet to be convicted of a crime, or who are serving sentences less than a year. Therefore, most individuals incarcerated in jails face quicker reentry into the community and concomitant challenges, including possible job loss, damaged relationships, and/or new legal/financial burdens (Petersilia, 2001; Zeng, 2020). As a result, the rate of jail reincarceration is substantially elevated, even compared to prison populations. For many, jail seems to be a "revolving door," with one in every four (~four million) individuals released being rearrested within the same year (Baillargeon et al., 2009; Sawyer & Wagner, 2023). Hence, the gains to be made from evidence-based policies that reduce incarceration, improve reentry outcomes, and stem recidivism are especially large when focusing on jail populations.

Beyond structural and contextual barriers, persons involved with the criminal legal system experience several individual-level risk factors that include difficulty regulating emotions, tolerating distress, and navigating difficult interpersonal situations (Apel et al., 2010; Ivanoff & Marotta, 2018; Roberton et al., 2015). As such, persons in jail can benefit from skills necessary to cope with their incarceration (e.g., tolerating a difficult cellmate, communicating effectively with a judge, adjusting to the uncertainty of a county jail) and to navigate the difficult situations they may encounter

Keywords: DBT; correctional programming; implementation science; implementation research

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This study:
In this paper the authors describe their experiences during the process of setting up and evaluating a DBT skills group in a jail in a rural county of Florida. The term jail here refers to an institution where there are detainees awaiting trial and convicted individuals serving a sentence of up to one year. Many of these inmates face immense life challenges once returning to their environments and thus very often reenter jail after short periods outside of it due to inadequate impulse control, aggression and a lack of other essential life and interpersonal skills. Consequently DBT can be regarded as a source of hope to reduce readmission rates and increase reintegration into society. There is promising but limited data on the effectiveness of DBT in forensic settings from other studies.
Due to a lack of personnel and short durations of stay the skills group consisting of 12 units of 90 minutes each (including mindfulness, emotion regulation, distress tolerance and interpersonal effectiveness skills) was organized twice a week over the course of 6 weeks. Participants would attend an additional introductory meeting and could enter the group at any given point in time.
The authors present a useful collection of adaptations, challenges and encouraging results we would like to share here:

Adaptations:
- Clinicians found it useful to be prepared for situations requiring conflict resolution between participants.
- Language of handouts and didactic material was simplified (e.g. using adolescent manuals).
- The team used various means of illustration making the content more accessible (e.g. the "Game of Real Life" or youtube videos explaining skills developed at Rutgers University).
- Some of the distress tolerance skills had to be adjusted to accessibility of means in a jail context.
- Creative use of incentives and rewards such as a two step certification of attendance (that some participants could use in trial to possibly positively influence sentencing).

Challenges:
- Sometimes a lack of jail personnel prevented participants from attending groups.
- The therapeutic team had to constantly inform jail employees about the benefits of the group in order to generate enough organizational support.
- Participants found it hard to keep their notes and handouts safe from other detainees.
- Video surveillance might have influenced the therapy process in group.
- Conflicting obligations and plans of detainees was a serious obstacle for regular attendance (court appearances, medical appointments, relatives' visits etc.).

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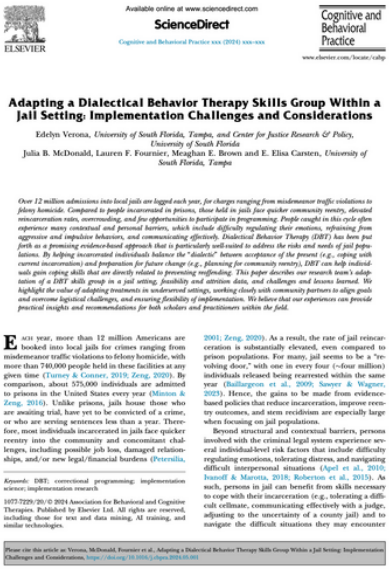
Encouraging results:

This paper does not present data on the therapeutic results. Other studies of DBT skills only programmes in forensic and non-forensic settings have demonstrated good effect sizes. We would however like to cite the author's examples from skills group discussions and feedback forms: "Participants describe de-escalating fights in their housing units using DEARMAN, preventing themselves from getting into physical altercations using STOP, using Cope Ahead prior to court appearances, and communicating more effectively with their families and partners using GIVE. In interactions with other inmates or jail staff, participants have also reported receiving positive remarks from staff for their behavior when using DBT skills. One participant remarked about what they learned in DBT, "I look at the entirety of the problem, pace my breathing, and also I like to do intensive exercise to relieve the stress I may be experiencing".



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Adapting a Dialectical Behavior Therapy Skills Group Within a Jail Setting: Implementation Challenges and Considerations

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EACH year, more than 12 million Americans are booked into local jails for crimes ranging from misdemeanor traffic violations to felony homicide, with more than 740,000 people held in these facilities at any given time (Turney & Conner, 2019; Zeng, 2020). By comparison, about 575,000 individuals are admitted to prisons in the United States every year (Minton & Zeng, 2016). Unlike prisons, jails house those who are awaiting trial, have yet to be convicted of a crime, or who are serving sentences less than a year. Therefore, most individuals incarcerated in jails face quicker reentry into the community and concomitant challenges, including possible job loss, damaged relationships, and/or new legal/financial burdens (Petersilia, 2001; Zeng, 2020). As a result, the rate of jail reincarceration is substantially elevated, even compared to prison populations. For many, jail seems to be a "revolving door," with one in every four (~four million) individuals released being rearrested within the same year (Baillargeon et al., 2009; Sawyer & Wagner, 2023). Hence, the gains to be made from evidence-based policies that reduce incarceration, improve reentry outcomes, and stem recidivism are especially large when focusing on jail populations.

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Interview with Michaela Swales – Insights and reflections on her journey in DBT

Hi Michaela, thank you for making time for this interview despite your busy schedule. Your achievements are truly inspiring - you've had an extraordinary career shaping the field of Dialectical Behaviour Therapy and clinical psychology. You've led the North Wales Clinical Psychology Programme and the Post-Graduate Diploma in DBT, mentoring countless professionals. As President of the World DBT Association and President of ESSPD, you've guided global conversations on personality disorders and evidence-based therapies. You've trained over a thousand professionals, established more than 400 DBT programs worldwide, and authored essential works like Dialectical Behaviour Therapy: Distinctive Features and Changing Behavior in DBT. Your contributions to the WHO's ICD-10 revision and your recognition with prestigious awards, including the Cindy Sanderson Outstanding Educator Award, speak volumes about your impact.

To start, could you tell our audience how you became involved in DBT?

It's a bit of a long story, but it's one I enjoy telling. When I first qualified as a clinical psychologist in 1992, I was fortunate enough to begin my career at Bangor University, which is located in the northwest of Wales. This was a joint NHS-academic position, and as part of it, I was pursuing my PhD under Mark Williams, one of the three people who developed mindfulness-based cognitive therapy. He was a very lovely clinician, lovely PhD supervisor. During one of our PhD supervision sessions, I said to him: "I have all these young people in the service who are harming themselves, and I don't know what to do with them," because at that time, my training had only included one morning that briefly touched on self-harm as a behavior. Mark replied, "That's very interesting. A woman from Seattle came to the research unit where I used to work while she was on sabbatical. She's developed a treatment for that and sent me a draft of her treatment manual to read. I haven't had time to look at it. Would you like to read it?" He gave me a draft copy of Marsha Linehan's treatment manual, including both the skills manual and the main treatment manual. I started by trying out a few techniques from the skills manual. Back then, it included strategies like holding ice cubes—there was no mention yet of putting your head in ice water. These techniques helped me better understand the clients I was working with. I had been trained in CBT, but I often found myself deviating from it. When I read what Marsha had written, I realized why I was deviating—it felt like I had found something that truly resonated and was incredibly helpful. Later, Mark funded my intensive DBT training in Seattle on the condition that I would teach others upon my return. That training opened many doors for me, including the opportunity to collaborate with Marsha's graduate students, such as Heidi Heard. My journey into DBT was unplanned, but it has been incredibly rewarding.

With such a rich history in DBT, what are some of your most memorable experiences working in this treatment?

I was incredibly fortunate in 2019 to be invited to deliver the speech at Marsha Linehan's retirement event in Seattle. That, for me, stands out as the most memorable moment in my career as a DBT therapist and trainer. It was a profound honor to stand in front of approximately 700 people in the room and pay tribute to Marsha Linehan. Yet, of course, in that moment, the only person in the room who truly mattered was Marsha herself, seated right in the front. I had never been so terrified in my entire life, but it was such a gift because, after that, nothing else has ever been as terrifying. What touched me even more about that experience was that one of my former clients contributed a short video as part of the presentation. It struck me deeply to see this person, who came from an incredibly remote part of rural Wales, from an

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impoverished background, and who had endured severe trauma, be able to speak directly to Marsha—thousands of miles away—about how DBT had transformed their life and made such a profound difference. On a more practical level, moments of progress with clients are equally meaningful. Receiving heartfelt letters from university students in my DBT program always moves me. Many of these students, often neurodivergent or part of the LGBTQ+ community, have shared how DBT not only improved their ability to function but also helped them feel truly seen for who they are. I think I'm continually humbled by the resilience of my clients, and it brings me immense joy to witness their progress against the odds. Seeing young people I worked with years ago who are now thriving, perhaps married and starting families, is particularly rewarding. I remember one young woman who once told me, "You said I would have this one day, and I didn't believe you. But you were right, and it was worth staying around for." Moments like these are the gifts this work provides, alongside all its challenges.

As DBT therapists, we use skills ourselves. What's been the hardest skill for you to learn?

Often, when people think of the hardest skill, and when I teach the hardest skill to learn, people say radical acceptance. I don't think I found that difficult. I think experiences in my early life—my father died when I was eight—taught me radical acceptance young. I'm naturally anxious, and I've always coped with anxiety by planning ahead. I was a natural "cope-aheader." The hardest thing was cultivating the capacity to be fully present—not planning my way out of something difficult, but being fully present, especially during difficulty or challenge. Bringing my mind to be fully present was the hardest thing to learn. What helped was lots of practice. I went on a five-day silent retreat, where there was nowhere to run and nothing else but being fully present with physical and emotional discomfort—not being in analytical, planning mind. I strongly recommend this for people. Not necessarily starting with a five-day retreat but practicing and cultivating mindfulness—not just as a DBT skill, but as something we practice to lead others and clients to be more mindful.

What is your favourite mindfulness practise then?

I love participating practices. My two favorites are: in skills class, throwing sounds, getting people to throw and catch sounds, and immersing themselves in it. When training, I like to get therapists to sing, especially online but also in person. I've done a lot of singing, but when I started, I wasn't a singer. At school, I was the type they told to mime the words, not sing. But I learned to sing by taking lessons, and it was hard for me. I encourage people because singing makes many feel self-conscious, and it's a powerful experience. Another favorite—and I hesitate to describe it because it's best experienced without explanation—is in a big group, either in a skills class or training. People silently choose two others in the circle and, when the bell rings, they must position themselves equidistant between the two. Everybody moves, and the experience unfolds from there. Try it and see what happens.

What distinguishes a successful DBT team from one that struggles?

Fundamentally, that's an empirical question and one I'm quite interested in. We're doing some work related to this, but it's a hard question to answer because so many variables are involved. I think some things are essential though. The first is that people must have enough time to do the work, especially when they're new to it, as they need more time than they might otherwise require. Time must be allocated to deliver the treatment comprehensively, and out-of-session coaching, which is often overlooked, must also be included. The other essential factor is the characteristics of the team members. People must fully embrace the model, being dialectical and non-judgmental. They need to let go of their attachment to being right while being willing to hold to their perspective when necessary. It's about having flexibility of thinking. There also needs to be a commitment to doing the treatment well and adhering to it. This treatment isn't for everyone, and people should be supported in leaving if it's not right for them. Other evidence-based treatments may work better for them. Finally, there must be a capacity to embrace dialectics and be non-judgmental, not only toward clients but also toward colleagues and the system.

Of course, as therapists, we all want to achieve the goal of becoming good therapists. Sometimes it feels like the beginning of DBT stretches on for so long. Is there something that distinguishes beginner therapists from more advanced therapists?

I think you're right that we all want to stay in beginner's mind and know that we can still learn. But what I was saying earlier connects with this: you stay in the beginning phase longer if you don't have many clients. If you treat a lot of clients, you'll learn faster. Unfortunately, many people learning DBT only have one or two clients at a time, which makes the process very slow. If you had a caseload of eight or ten clients, you'd learn it much faster. In terms of what novice therapists commonly struggle with, and what's been written about, the first issue is often session structure. Novice therapists are often used to approaches where they follow the client, rather than leading the client, as is necessary in DBT.

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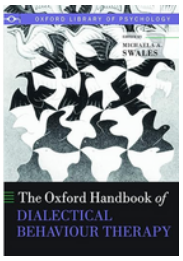
Once therapists have the structure down, the next challenge is behavioral specificity. In the behavioral analysis, therapists need to be specific about emotions, thoughts, and sensations, separating them clearly. DBT only has solutions for emotions, thoughts, and sensations—it doesn't have solutions for big constructs, which are common in other psychotherapies, like abandonment or rejection. We treat these constructs by breaking them into their component parts. In the UK, where we are fortunate to be funded by the government to train large numbers of therapists, I spent the summer listening to therapy sessions. What I noticed is that therapists often struggle to be dialectical in the moment—recognizing dialectical tensions, taking different approaches, or seeing both sides of a situation.
Another issue is that novice therapists often focus heavily on skills, which are very important—they are the driving engine of the treatment—but they're not the entirety of DBT. To get clients to use skills effectively, you also need to attend to other aspects, like exposure, contingency management, and cognitive modification.

Do you have any final words for our readers?

I'm in a very privileged position now. People listen to what I say, and when I suggest doing things a certain way, they tend to take notice. But it wasn't always like this. When I first started doing DBT, I was 28 years old. I had no track record. I was nobody, and it was difficult.
I think my advice would be to trust in DBT—it's a very rich treatment that keeps on giving if you study it and focus on the central tenets Marsha built into it. Really understanding that our clients are doing the best they can and having compassion for them is essential. Trusting in the treatment can take you a long way. Of course, it's not a perfect treatment. We know that no treatment is perfect, but If you're struggling with a client, what often happens is that therapists think, "I know what to do in a different model," or, "I'm going to switch models to try something else." But the key is to seek consultation from your team or others and ask, "How would DBT tackle this problem?" because there's usually a solution within the model. That process will really help you learn and grow.

Thank you, Michaela, for sharing your journey and insights. This will undoubtedly inspire our readers!

Books by Professor and World DBT Association president **Michaela Swales...**



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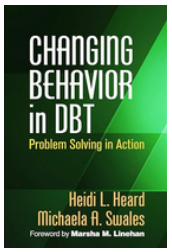

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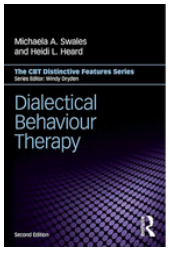

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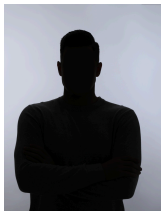

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