European Dialectical Behaviour Therapy Association

NEWSLETTER

#4 January 2025

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Paths are made by walking them.
– Franz Kafka

I hope you had a successful start into the new year, whether you jumped, stumbled, slid, staggered or simply fell asleep into it. Whatever happened in the old year is over and done with, and we can start afresh today.

What does the EDBTA have in store for you in 2025?
The webinars are starting: Every first Sunday of the month at 7 pm CET, you can listen to the world's leading DBT experts on selected topics on the live stream. 90 minutes, and free of charge: https://edbta.eu/live/
The congress in Gdansk is opening its doors and is waiting for your registrations: event.fourwaves.com/edbta2025/pages. We are working on the concept of an EDBTA Summer School.

In today's newsletter, we are pleased to introduce Jordan. As a representative of the MENA region (Middle East North-Africa), like Egypt, Jordan is an associate member of EDBTA. The aim is to support this region in becoming an independent chapter of the DBT world organization in the medium term. Just like the Latin America Chapter and the Asia-Pacific Chapter. It is obvious that the political and economic circumstances are a real challenge not only for DBT development, and that we are very happy to support our friends from the Middle East.

Perhaps DBT, grounded in Buddhist thought, can help to release the tension a little, or, to put it in the words of Sawaki Kôdô Rôshi: "We carry a lump of granite in our heads. This is what I call our "individuality": we do not want to let go of what is ours personally. The men insist on being men, the women insist on being women. Both sides stubbornly hold on to their points of view. Practice must consist of loosening this stubborn clinging. If you are truly willing to let go completely, you will no longer be attached even to your own life. Therefore, it is important for the practice to develop a flexible and soft mind, instead of holding on to your narrow frame. Do not get caught up in trivialities, but dedicate yourself to the unlimited, cosmic whole. When you let go of your idea of an "ego," you will discover yourself in your counterpart. In all things – a cup of tea, a pair of wooden sandals – you will discover yourself. And all things will thus take on the greatest importance for your life: this is what it means to practice Zen."

In this sense...

Happy New Year

Prof. Martin Bohus, MD
President EDBTA

JANUARY NEWS

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DON'T FORGET TO REGISTER 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.

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 in January!

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!

EDBTA WEBINAR

START THE NEW YEAR WITH MINDFULNESS IN DBT

5TH OF JANUARY, 7 P.M. CET, GO TO LIVE STREAM HERE!!!

PhD Jan Glasenapp!

Jan completed his psychology studies at the University of Bielefeld in 1997 with distinction and pursued post-graduate training in Client-centered Therapy, Transaction Analysis, and Cognitive Behavioral Therapy. Certified as a psychological psychotherapist in 2001, he worked in private practice in Berlin and Schwäbisch Gmünd. Since 2003, he has been a teaching therapist and supervisor at various psychotherapy academies and a consultant for mental health care institutions. Specializing in DBT and Mindfulness in psychotherapy, Jan has worked with Prof. Marsha Linehan. He has taught and trained in China since 2016 and is a supervisor at Nanjing Brain Hospital. Appointed guest professor in 2022 at SCNU, he became an associate professor at Nanjing Medical University and visiting professor at Jiao Tong University in 2024. His focus is on enhancing psychotherapy interventions through mindfulness integration.

On Sunday, 5th of January, at 7 p.m. Central Europe Time, 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:

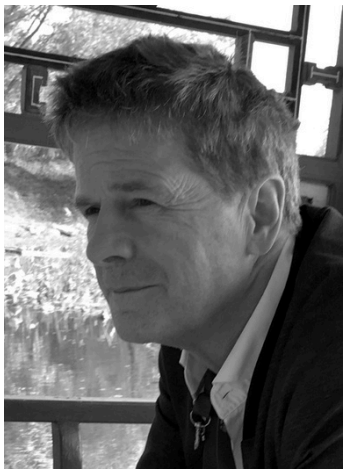
- the observation of opportunities to strengthen compassion for oneself and others and to strengthen prosocial behavior;
- the expansion of the ability to concentrate on different sensations;
- the expansion of the ability to not only perceive these impressions, but also to accept them in their never-ending 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 [...].”

**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.*

EDBTA WEBINAR

HOW TO TREAT COMPLEX PTSD IN BPD-CLIENTS

FEBRUARY 2ND, 7 P.M. CET, GO TO LIVE STREAM HERE!!!



Dr. Martin Bohus

Dr. Martin Bohus is a renowned expert in the pathological mechanisms and treatment options for borderline personality disorder (BPD) and complex PTSD. Based at Heidelberg University, where he held the Chair of Psychosomatic Medicine and Psychotherapy, he has led extensive research at the Central Institute of Mental Health in Mannheim. With over 480 publications, Dr. Bohus is the founder and editor of the journal Borderline Personality Disorder and Emotion Regulation. He is also the president of the European DBT Association (EDBTA). His professional journey was influenced by meeting Marsha Linehan in 1994, which sparked his long-term collaboration, particularly in the development of DBT-PTSD. Dr. Bohus is proud of his work in converting therapeutic experiments into treatment programs and advancing DBT-PTSD, which he has researched for over a decade. His upcoming webinar will cover the disorder model of complex PTSD, its treatment strategies, and the evidence backing their effectiveness.

DBT-PTSD an evidence based program for complex PTSD after sexual abuse.

DBT-PTSD is a modular program developed by Martin Bohus in close cooperation with M. Linehan. It is specifically tailored to treat complex PTSD related to childhood abuse. Complex PTSD is characterized by dysfunctional memory processing (e.g. intrusions and flashbacks), severe problems in affect regulation (e.g. intense and maladaptive emotions), negative self-concept (e.g. guilt, shame, and self-hate), problems in social interaction (e.g. mistrust, alienation) and often complex dysfunctional behavioral patterns like self-harm, suicide attempts or aggressive outbursts. To target these core domains, DBT-PTSD merges evidence-based therapeutic strategies: principles and skills of DBT, trauma-specific cognitive and exposure-based techniques, compassion focused interventions, and behavior change procedures. The treatment program is designed to be delivered as a residential program (three-months) or in an outpatient setting (45 weeks). Two large RCTs reveal large effect sizes in all relevant domains and significant superiority of DBT-PTSD to Cognitive Processing Therapy (CPT). Accordingly, DBT-PTSD has currently the best scientific evidence for effective treatment of complex PTSD.

COUNTRY INTRODUCTIONS

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Jordan

In 2016, the Maria Den Braven Center founded the first Dialectical Behavior Therapy (DBT) programme in Amman, Jordan. Situated in the heart of a war-ridden region, Jordan's population has faced a multitude of problems stemming from emotion dysregulation, such as substance use, self-harm and suicidality. The journey began with Dr. Basma Al-Kilani, whose interest in DBT grew after attending the APS conference in Australia in 2012. Inspired by what she learned, Dr. Basma and her team pursued comprehensive DBT training and completed the DBT Intensive Training with British Isles DBT. Initially starting with 4 practitioners, the team has since grown to 9 practitioners. As DBT was placing its roots in Jordan, Dr. Basma witnessed first-hand the successful and effective impact it had on individuals, leading her to realize that the region is in dire need of this important treatment approach. She sought to bring DBT to the larger regional community across the Middle East and North Africa (MENA) through pursuing the DBT affiliation. Today, Dr. Basma is the director of DBT MENA, a Behavioral Tech Tier 2 affiliation with a strong vision of disseminating DBT in the region.

ASSOCIATION IN PROGRESS

There is currently no Jordanian DBT Association, we are in the process of looking into possibilities of founding a DBT association with the aims of disseminating the treatment and increasing awareness of the treatment and its need in the country.

How is training organized?

Training is organized through DBT MENA, a Tier 2 affiliate of Behavioral Tech. To date, DBT MENA has trained over 200 practitioners across the region and has helped establish 10 dedicated DBT teams, who currently run over 15 skills classes across the region. Training is delivered by Behavioral Tech trainers, the only DBT MENA certified trainer – Dr. Basma Kilani, and 4 trainers in training under the supervision of certified DBT trainers. DBT MENA offers globally accredited DBT Training in the Arabic language, making this treatment accessible to a wider audience across the MENA region.

Active local therapy programmes

DBT is currently offered in the Maria Den Braven Center, a private multidisciplinary mental health center in Amman, Jordan. The team is home to 9 members that are comprehensively trained in DBT. The Maria Den Braven DBT programme currently runs 2 DBT Adult Standard Skills Classes, with plans on starting 2 additional DBT Skills Classes (Standard Adults and Standard Adolescents) within the next 4 months). Given the limited availability of DBT programmes and consultation teams across the MENA region, the Maria Den Braven Center conducts the consultations teams online in order to include DBT practitioners from across the region. The offered programmes are standard DBT for adults and standard DBT for adolescents, with durations ranging from 6 months to 2 years. The programme is a comprehensive DBT programme offering Individual Therapy, Skills Classes, Consultation Team Meetings, Phone Coaching and Consultation to the Client. Currently, the Maria Den Braven Programme is the only comprehensive DBT programme in Jordan, though additional programmes are in development. While there are other DBT services available across a variety of centers, these are not yet comprehensive DBT programmes. The region also faces a significant shortage of trained DBT practitioners, which limits the availability of comprehensive DBT services in Jordan and throughout the broader MENA region.

COUNTRY INTRODUCTIONS

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Jordan

Current challenges

- Applicability of the model: Exploring and understanding the differences of applicability of the model in different ethnocultural backgrounds than those in which the treatment was researched. We have found that some components of the treatment needed changes.
- Cultural and Linguistic Adaptability: DBT resources are all in English, which raises many issues when translating DBT terminology into different languages. For example: many emotions are conceptually different and require a different linguistic translation in Arabic, while other emotions in the Arabic language do not have a direct English translation.
- Economic Disparities: DBT treatment is in high demand, and DBT training is costly. This poses a disparity between the demand for the treatment and its accessibility.

Maria Den Braven center
Psychological, Educational Consultations & Training

EDBTA representative:
PhD Basma Kilani

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

DBT is flourishing in the region, and we would like to cultivate a community of skilled practitioners who support and uplift one another in pursuit of a shared vision. To further advance DBT in a way that is culturally and linguistically adaptable, we need to expand the research base, ensuring that DBT continues to evolve to meet the unique needs of the region. Additionally, given Jordan's sociopolitical challenges, we need support in training individuals to deliver effective treatment. International funding and bursaries for training would enable us to expand the DBT community, ensuring a growing network of practitioners. This support would also allow us to train individuals to provide consultancy services, further strengthening adherence to the DBT model and enhancing its effectiveness across the region. As one of the first DBT teams in the area, we are in a fortunate position to contribute our experience, expertise, and resources. By fostering collaboration and offering support, we can play a pivotal role in shaping the future of DBT in the region.

Plans for the future

DBT in Jordan aims to establish a community of equipped DBT practitioners and teams across the country, who will be able to attend to the needs of many individuals that would benefit from DBT and help them live a life worth living. To support our goal, we aim for all DBT materials to be made fully accessible in Arabic, ensuring that language is not a barrier to learning and application. Additionally, our long-term plan includes the establishment of a certification board to ensure proper evaluation of the treatment application.

RESEARCH DIGEST

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Digital Interventions for Symptoms of Borderline Personality Disorder: Systematic Review and Meta-Analysis

Julia A B Lindsay, Niall M McGowan, Thomas Henning, Eli Harriss, Kate E A Saunders
J Med Internet Res. 2024; 26: e54941. Published online 2024 Nov 29. doi: 10.2196/54941


JOURNAL OF MEDICAL INTERNET RESEARCH Lindsay et al

Review

Digital Interventions for Symptoms of Borderline Personality Disorder: Systematic Review and Meta-Analysis

Julia A B Lindsay[1], BSc; Niall M McGowan[2], PhD; Thomas Henning[2], BA; Eli Harriss[3], MSc; Kate E A Saunders[1,2], MRCPsych, DPhil

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Abstract

Background: Borderline personality disorder (BPD) is a mental health condition with insufficient care availability worldwide. Digital mental health interventions could reduce this treatment gap. Persuasive system design (PSD) is a conceptual framework outlining elements of digital interventions that support behavior change.

Objective: This systematic review aims to characterize digital interventions targeting BPD symptoms, assess treatment efficacy, and identify its association with intervention features, including PSD elements.

Methods: A systematic review of automated digital interventions targeting symptoms of BPD was conducted. Eligible studies recruited participants aged ≥18 years, based on a diagnosis of BPD or one of its common comorbidities, or as healthy volunteers. OVID Embase, OVID MEDLINE, OVID PsycINFO, and the Cochrane Central Register for Controlled Trials were searched on July 19, 2022, and February 28, 2023. Intervention characteristics were tabulated. A meta-analysis of randomized controlled trials (RCTs) determined treatment effects separately for each core symptom of BPD using Hedges *g*. Associations between the treatment effect and intervention features, including PSD elements, were assessed by subgroup analysis (Cochran *Q* test). Risk of bias was assessed using the Cochrane Risk of Bias 2 tool for RCTs and the National Institutes of Health Quality Assessment Tool for pre-post studies.

Results: A total of 40 (0.47%) publications out of 8520 met the inclusion criteria of this review, representing 6611 participants. Studies comprised examinations of 38 unique interventions, of which 32 (84%) were RCTs. Synthesis found that included interventions had the following transdiagnostic treatment targets: severity of BPD symptoms (4/38, 11%), suicidal ideation (17/38, 45%), paranoia (5/38, 13%), nonsuicidal self-injury (5/38, 13%), emotion regulation (4/38, 11%), and anger (3/38, 8%). Common therapeutic approaches were based on dialectical behavioral therapy (8/38, 21%), cognitive behavioral therapy (6/38, 16%), or both (5/38, 13%). Meta-analysis found significant effects of digital intervention for both symptoms of paranoia (Hedges *g*=−0.52, 95% CI −0.86 to −0.18; *P*=.01) and suicidal ideation (Hedges *g*=−0.13, 95% CI −0.25 to −0.01; *P*=.03) but not overall BPD symptom severity (Hedges *g*=−0.17, 95% CI −0.42 to 0.10; *P*=.72). Subgroup analysis of suicidal ideation interventions found that evidence-based treatments such as cognitive behavioral therapy and dialectical behavior therapy were significantly more effective than alternative modalities (Cochran *Q*=4.87; *P*=.03). The degree of human support was not associated with the treatment effect. Interventions targeting suicidal ideation that used reminders, offered self-monitoring, and encouraged users to rehearse behaviors were associated with a greater reduction in ideation severity.

Conclusions: Evidence suggests that digital interventions may reduce the symptoms of suicidal ideation and paranoia and that the design of digital interventions may impact the efficacy of treatments targeting suicidal ideation. These results support the use of transdiagnostic digital interventions for paranoia and suicidal ideation.

https://www.jmir.org/2024/1/e54941 J Med Internet Res 2024 | vol. 26 | e54941 | p. 1
(page number not for citation purposes)

FO

In the USA alone there are nearly 6000 people seeking therapeutic services for BPD for one provider of evidence-based care. Therefore there is a pressing need to identify solutions to reduce the vast treatment gap. For this publication the authors identified 40 studies (representing a total of 38 clinical interventions and 6611 participants) examining the effects of digitally based interventions on symptoms associated with borderline personality disorder (BPD). It is worth noting that the majority of participants were not assessed to confirm a formal diagnosis. Many studies rather focussed on the change of the following transdiagnostic treatment targets: severity of BPD symptoms (4/38, 11%), suicidal ideation (17/38, 45%), paranoia (5/38, 13%), nonsuicidal self-injury (5/38, 13%), emotion regulation (4/38, 11%), and anger (3/38, 8%). 8 out of 38 interventions were based on DBT, 6 on CBT, 5 out of the 38 interventions combined elements of both CBT and DBT. 32 of the trials were randomized controlled trials (RCTs). The study includes a meta-analysis of these RCTs, determining treatment effects separately for each core symptom of BPD. The authors also examined a possible impact of so-called persuasive system design elements (PSD) for suicide ideation. PSD elements are features of a digital intervention created to enhance adherence such as rewards, reminders, reduction of tasks to small steps, self-monitoring and rehearsal.

Key findings

- A small and non-significant effect on BPD symptoms as a whole was found (N=3; Hedge g=–0.17, 95% CI –0.42 to 0.10; P=.11).
- The effect on suicidal ideation was small but significant (N=18; Hedges g=–0.13, 95% CI –0.25 to –0.01; P=.03). Comparing evidence-based interventions to non-evidence-based treatments the authors found a significant difference (Standard Mean Difference –0.21 vs 0; Cochran Q=4.87; P=.03). Reminders, opportunities for self-monitoring and opportunities for rehearsal were associated with a larger positive change in suicide ideation.
- Although interventions for symptoms of paranoia only lasted for 1 session to two weeks there was a moderate and significant therapeutic effect (N=4; Hedges g=–0.52, 95% CI –0.86 to –0.18; P=.01).
- Non-suicidal self-injury, emotion regulation and anger did not change significantly during the course of the interventions.

Clinical implications

- Findings of this study suggest that digital interventions in general seem unlikely to be able to replace evidence-based face-to-face care for people suffering from BPD.
- There is evidence for a small to moderate positive effect on suicidal ideation and paranoia.
- Self-monitoring, reminders and rehearsal appeared to be useful reinforcing components of digital interventions.
- Since this study is based on a sample of unspecific clinical interventions, the results cannot be generalized to DBT.

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RESEARCH DIGEST

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- The current state of research on online-based DBT for borderline patients is presented in two recent reviews (Lakeman et al., 2022; van Leeuwen et al., 2021). Van Leeuwen et al. (2021) described the whole range and heterogeneity of Tele-DBT elements under investigation in previous studies and how they have been integrated into DBT. Overall, they included 41 studies, focusing on any of these digital intervention strategies to use within or between sessions or as standalone treatment. However, only two of these trials have investigated online DBT by therapists via videoconferencing systems for BPD patients specifically (Lopez et al., 2020; Salamin et al., 2020, details see below). In another review Lakeman et al. (2022) similarly reviewed the online-delivery of DBT for a range of different mental disorders. They showed that attendance tended to be higher in online format and clinical improvements were comparable to in person format, though many of the primary trials also highlighted challenges related to risk management, therapist preparedness and technical difficulties. The authors concluded that despite various challenges, the online delivery of DBT programs is more accessible and feasible and equally acceptable, safe and effective as face- to-face delivery. However, of the 11 trials included in this review, only one trial was conducted with BPD patients (Alavi et al., 2021), therefore these conclusions are not necessarily generalizable to BPD-specific populations.

RESEARCH DIGEST

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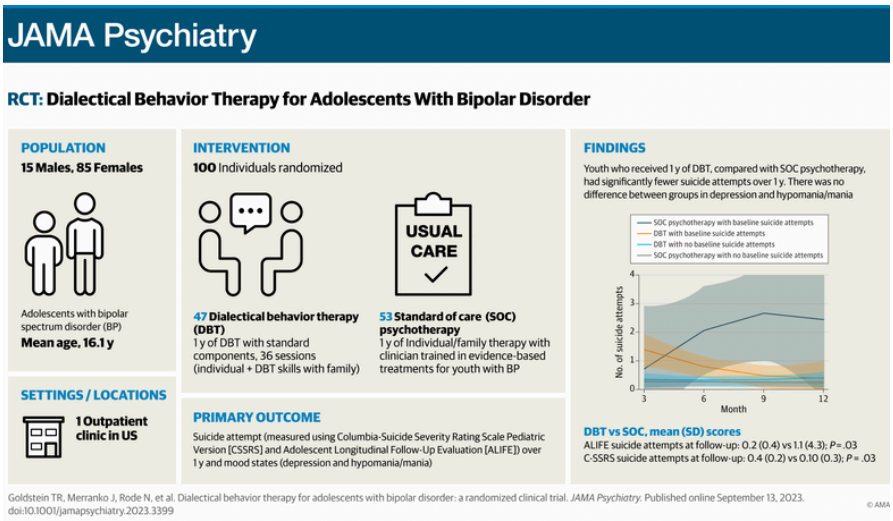
Dialectical Behavior Therapy for Adolescents With Bipolar Disorder: A Randomized Clinical Trial

Tina R. Goldstein, John Merranko, Noelle Rode, Raeanne Sylvester, Nina Hotkowski, Rachael Fersch-Podrat, Danella M. Hafeman, Rasim Diler, Dara Sakolsky, Peter Franzen, Boris Birmaher. JAMA Psychiatry. 2024 Jan; 81(1): 15–24. Published online 2023 Sep 13. doi: 10.1001/jamapsychiatry.2023.3399



This Study

Suicide in adolescents suffering from bipolar disorder is one of the leading causes among young people dying related to mental illness. Up to date no psychosocial intervention has been established to specifically target the risk of suicide in early onset bipolar disorder. This study aimed at investigating whether Dialectical behaviour therapy (DBT) applied for 1 year could reduce the risk of adolescent suicide more effectively than standard of care (SOC) psychotherapy. Teenage participants from age 12 to 18 recruited from a specialized clinic for bipolar disorder were randomly assigned to a DBT group (18 individual DBT sessions and 18 family skills training sessions conducted with the family unit; n = 47) or a control group receiving SOC psychotherapy (schedule clinically determined; n = 53). Additionally everyone received medication management. All participants and their parents were assessed quarterly and reported similar rates of suicide attempts at intake.

Key findings:

- DBT participants reported significantly fewer suicide attempts over follow-up compared with SOC participants controlling for baseline attempts. DBT was significantly more effective than SOC psychotherapy at decreasing suicide attempts over 1 year.
- Improvements in depression, mania and hypomania were similar across both arms of the trial.
- Emotional dysregulation measured by the Difficulties in Emotion Regulation Scale (DERS) improved to a greater extent in the DBT group. This improvement was shown to have a beneficial and growing moderating effect on the number of suicide attempts over the duration of treatment.

Limitations

- Participants receiving SOC psychotherapy attended significantly fewer sessions than participants in the DBT arm (DBT: a mean of 23.8 sessions including 14.3 individual DBT sessions and 9.8 family skills training sessions, SOC psychotherapy: a mean of 13.1 sessions).
- 85% of participants were females, 74% were non-Hispanic whites, mostly from a USA based middle-class background potentially reducing generalizability.

RESEARCH DIGEST

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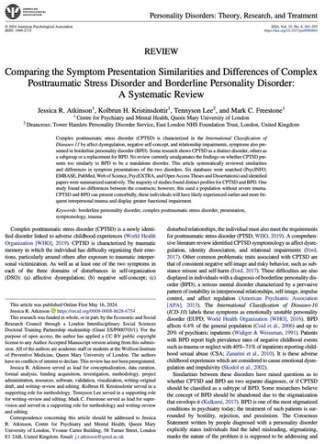
Comparing the Symptom Presentation Similarities and Differences of Complex Posttraumatic Stress Disorder and Borderline Personality Disorder: A Systematic Review


Personality Disorders: Theory, Research, and Treatment

REVIEW

Comparing the Symptom Presentation Similarities and Differences of Complex Posttraumatic Stress Disorder and Borderline Personality Disorder: A Systematic Review

Jessica R. Atkinson, Kolbrun H. Kristinsdottir, Tennyson Lee, and Mark C. Freestone

Jessica R. Atkinson, Kolbrun H. Kristinsdottir, Tennyson Lee, Mark C. Freestone
Personality Disorders: Theory, Research, and Treatment. 2024 Apr;15(4):241–253. Published online 2024 May 16. doi: 10.1037/per0000664

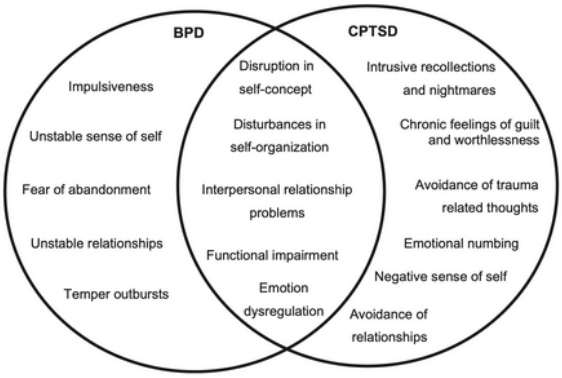
This study:
This systematic review investigated similarities and differences in symptom presentation between Complex Posttraumatic Stress Disorder (CPTSD) and Borderline Personality Disorder (BPD). The researchers followed the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines. Literature search was conducted across six databases using targeted search terms such as "BPD," "CPTSD," and their associated diagnostic labels. Studies published from 2012 onward were included to align with the ICD-11 introduction of CPTSD. 11 eligible studies met the inclusion criteria of focusing on adult populations diagnosed with either BPD or CPTSD and specifically addressing symptom presentation comparisons.

Key findings:

- CPTSD is characterized by trauma-specific symptoms (e.g., re-experiencing, avoidance, guilt, and emotional numbing) and relationship difficulties, while BPD is marked by impulsivity, unstable relationships, intense fear of abandonment, and self-harm. Despite some symptom overlap, such as emotional dysregulation and disturbances in self-concept, the two disorders remain largely distinct.
- Both CPTSD and BPD are strongly linked to adverse childhood experiences, particularly interpersonal trauma. CPTSD is more closely associated with cumulative and severe trauma, whereas BPD is tied to a wider range of childhood adversities.
- People with both CPTSD and BPD diagnoses often exhibit more significant functional impairment, more intense emotional dysregulation, and earlier trauma exposure compared to those with only one of the diagnoses. The overlapping symptoms, such as emotional reactivity and chronic emptiness, make differential diagnosis more challenging, emphasizing the need for more precise diagnostic tools.

The study underscores the critical importance of accurate differential diagnosis between CPTSD and BPD, as their treatment approaches differ significantly. Clinicians must focus on specific symptoms that distinguish the two, such as the traumatic stressors and PTSD symptoms in CPTSD, versus the impulsivity, self-harm, and instability in BPD. Although there is symptomatic overlap, particularly in self-concept, affect regulation, and interpersonal relationships, careful attention to symptom specificity is essential to avoid over-diagnosing comorbid conditions.

Figure 4
Venn Diagram of the Overlap of Symptom Presentations of CPTSD and BPD



RESEARCH DIGEST

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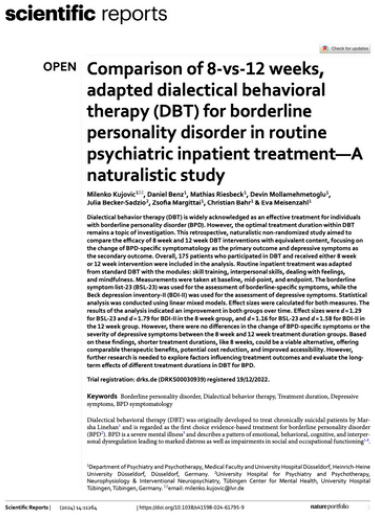
Comparison of 8-vs-12 Weeks, Adapted Dialectical Behavioral Therapy (DBT) for Borderline Personality Disorder in Routine Psychiatric Inpatient Treatment–A Naturalistic Study


scientific reports

OPEN Comparison of 8-vs-12 weeks, adapted dialectical behavioral therapy (DBT) for borderline personality disorder in routine psychiatric inpatient treatment—A naturalistic study

Milenko Kujovic, Daniel Benz, Mathias Riesbeck, Devin Mollamehmetoglu, Julia Becker-Sadzio, Zsofia Margittai, Christian Bahr, Eva Meisenzahl

Scientific Reports. 2024; 14:11264. Published online 2024. doi: 10.1038/s41598-024-61795-9

This study:

This study is comparing the effectiveness of 8-week and 12-week DBT in residential psychiatric treatment of patients with borderline personality disorder (BPD). The main aim was to assess whether a shortened 8-week residential DBT programme is as effective as a standard 12-week residential programme, focusing on BPD-specific symptom change as the primary outcome and idepressive symptom change as the secondary outcome. Participants were 175 patients with a diagnosis of BPD who were divided into two groups: one received an 8-week DBT programme and the other a 12-week DBT programme. The DBT programme included skills training, interpersonal skills, dealing with feelings, and mindfulness. In the 12-week group, patients were able to repeat and practice the content at additional times, but there were no differences in content or skill training. Data were collected three times: pre-treatment (baseline), mid-treatment (after 4 weeks in the 8-week group and after 6 weeks in the 12-week group), and post-treatment (at week 8 or 12, respectively) employing Borderline Symptom List-23 (BSL-23) and Beck Depression Inventory-II (BDI-II). Linear mixed models with repeated measures were used for data analysis, including group, time and group*time interaction as fixed effects, and patient as a random effect. Effect sizes were also calculated using the estimated means, divided by the pooled standard deviation at baseline.

Key findings:

- BPD-specific symptoms decreased over time in both groups (8-week and 12-week DBT groups). This was confirmed by linear mixed model analysis, which showed a significant time effect ($p < 0.001$) for BSL-23 scores. Depressive symptoms also improved significantly over time in both groups. Again, the linear mixed model results showed a significant time effect ($p < 0.001$) for BDI-II scores. The effect sizes for BPD symptom reduction (BSL-23) were $d = 1.29$ in the 8-week group and $d = 1.16$ in the 12-week group, and for depressive symptom reduction (BDI-II) they were $d = 1.79$ in the 8-week group and $d = 1.58$ in the 12-week group.
- No significant differences were found between the 8-week and 12-week DBT groups in terms of BPD-specific symptom reduction. Both the main effect of group and the interaction between group and time were not statistically significant ($p = 0.85$ and $p = 0.11$, respectively). This means that the 8-week programme was as effective as the 12-week programme in reducing BPD symptoms. Similarly, there was no significant difference between the groups in terms of reduction in severity of depressive symptoms. The main effect of group and the interaction between group and time were not statistically significant ($p = 0.78$ and $p = 0.26$, respectively). Thus, both treatment groups showed similar reductions in depressive symptoms.

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The authors argue that the lack of significant differences between 8-week and 12-week DBT programs can be explained by several factors. Firstly, while the 12-week group consisted of highly motivated participants, motivation alone did not lead to additional benefits, suggesting that extended therapy duration may not be essential for effectiveness. Secondly, the "good enough" model indicates that therapy can be effective when patients are sufficiently engaged, even in shorter time frames. The authors also note that patients with BPD may respond quickly to DBT, meaning the extra 4 weeks in the 12-week group did not yield proportional improvements. Moreover, shorter DBT programs, like a 5-day intensive course, can be equally effective, highlighting the importance of intensity over duration. Additionally, there were no significant differences in content or skills training between the two groups, suggesting that extended time for repetition did not provide major added benefits. The authors also point out that longer treatments could disrupt daily life, hindering real-world goal achievement. Finally, shorter programs may be more cost-effective and accessible, increasing availability for a larger patient population. Although the study has limitations (e.g. it's not an RCT, the 12-week group was small (n=22) and there was no control group), it suggests that shorter DBT programs can be just as effective as longer ones, offering additional benefits in cost and accessibility.

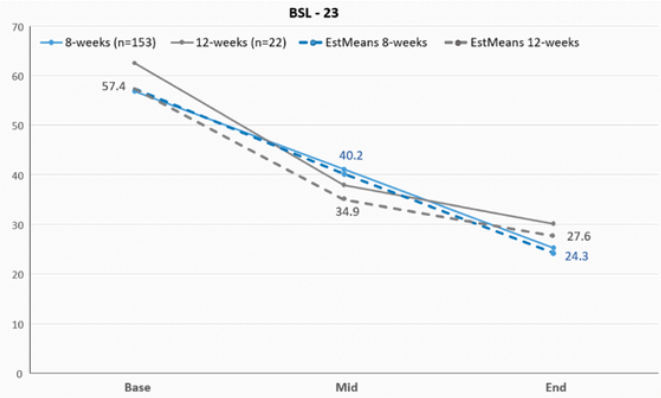

Figure 1. Observed and estimated percentile ranks regarding the BSL-23 for both groups on all assessment time points: Base, mid (after 4 weeks for 8 weeks treatment and after 6 weeks for 12 weeks treatment) and end (after 8 weeks for 8 weeks treatment and after 12 weeks for 12 weeks treatment).

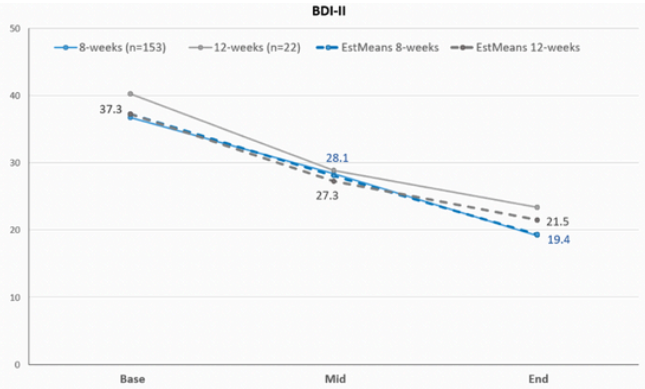

Figure 2. Observed and estimated sum scores for BDI-II for both groups over time; 'Mid' = after 4 weeks for 8 weeks treatment and after 6 weeks for 12 weeks treatment; 'End' = after 8 weeks for 8 weeks treatment and after 12 weeks for 12 weeks treatment.

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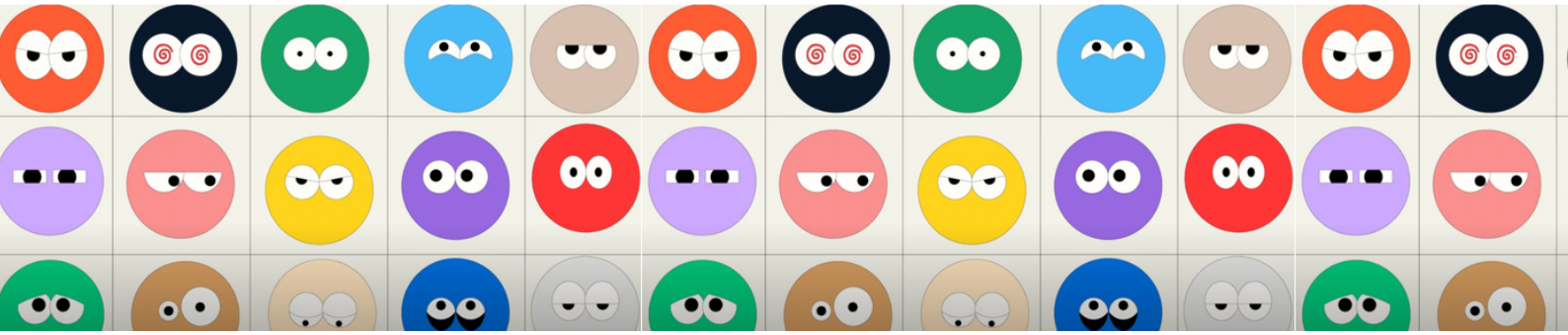
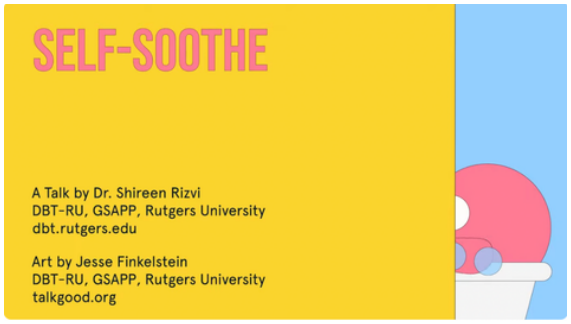


Conveying the essence of DBT skills: Short videos created by Shireen Rizvi and Jesse Finkelstein (Rutgers University)

Have you ever wished you could quickly refresh your understanding of the Wise Mind skill? Or perhaps you've been curious about finding a new way to explain what radical acceptance really means? And then there are those moments when it would be incredibly helpful to engage the "snoozing" members in your group.

These are just a few examples of when you might consider incorporating one of the videos created by Shireen Rizvi and Jesse Finkelstein. These short, engaging videos are aligned with the original worksheets and feature beautiful animations that effectively convey the message through a nonverbal channel. For many of us, the animations not only help with memorization but also offer a practical visual model for applying the skills in real-life situations. Additionally, the animated format has the potential to increase accessibility for neurodiverse populations.

If you're interested, we encourage you to explore these videos.
You can find them on YouTube by searching for "DBT-RU skills." (link)



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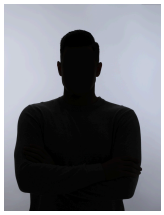

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