European Dialectical Behaviour Therapy Association

# NEWSLETTER

#6 March 2025

An old silent pond–
a frog jumps into the pond,
splash! Silence again.

– Matsuo Bashō

## *Dear Colleagues and Friends!*

*Spring is more than just a season of renewal; it is a force of resistance against stagnation, a moment of transformation that defies the cold inertia of winter. Bashō's famous haiku captures this essence: a quiet, seemingly unchanging pond is disrupted by a single, decisive action—the frog's leap. This sudden movement shatters the stillness, symbolizing the power of change, resilience, and the courage to break free. And then silence again.*

*Dialectical Behavior Therapy (DBT) emphasizes the balance between acceptance and change. Just as spring does not reject winter but grows from it, DBT teaches that resistance is not about denying reality but about embracing the possibility of transformation. The frog's leap mirrors the DBT concept of "committed action" - a mindful choice to disrupt old patterns despite fear or uncertainty.*

*Spring's resistance is not aggressive; it is patient yet persistent. Buds push through frozen ground, rivers swell as ice melts, and warmth slowly overcomes the cold. This natural progression reflects the essence of radical acceptance in DBT: acknowledging what is while actively fostering growth.*
*In times of personal and political struggle, we can look to spring as a reminder that resistance does not always come in the form of loud rebellion. Sometimes, it is the quiet persistence of a single leap, a first step toward change, that ultimately transforms the landscape of our lives. However, all the incredible noise of today will be silent again tomorrow.*

*DBT opens our minds for serenity and wisdom.*

**Prof. Martin Bohus, MD**
**President EDBTA**

# MARCH NEWS

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## GLOBAL LAUNCH OF THE WHO GUIDANCE ON MENTAL HEALTH POLICY AND STRATEGIC ACTION PLANS

The World Health Organization (WHO) is set to virtually launch its new Guidance on Mental Health Policy and Strategic Action Plans on Tuesday, **March 25, 2025, from 13:00 to 14:30 CET**. This event will detail the updated guidance and its anticipated impact on global mental health initiatives.

The updated guidance builds upon the Comprehensive Mental Health Action Plan 2013–2030, which was extended in 2019 to align with the 2030 Agenda for Sustainable Development. This plan emphasizes effective leadership, community-based mental health services, promotion and prevention strategies, and strengthened research.

The upcoming launch will provide stakeholders with insights into the new guidance and its role in advancing global mental health objectives.

Register now for the virtual launch event here:
https://who.zoom.us/webinar/register/WN_1ML12R9hT-ehZvH3J3DuvA

## DON'T FORGET TO REGISTER!

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

**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.

# MARCH NEWS

edbta.eu

## **ESSPD CLINICAL WORKSHOP-CONFERENCE 2025:** DEALING WITH ALLIANCE RUPTURES–PERSPECTIVES FROM DIFFERENT THERAPIES

The European Society for the Study of Personality Disorders (ESSPD) has announced its upcoming clinical workshop-conference, scheduled for **June 5–7, 2025, in Riga, Latvia.** The event, themed "Dealing with Alliance Ruptures: Perspectives from Different Therapies," aims to provide mental health professionals with insights and strategies to address challenges in therapeutic alliances across various treatment modalities.

The conference will start with an academic overview of research into alliance ruptures in the treatment of personality disorders, offering participants a comprehensive theoretical foundation. This will be followed by a panel discussion featuring case presentations by local hosts, during which workshop leaders will share their approaches to managing alliance issues, either through descriptions or demonstrations of potential responses.

Over the subsequent two days, attendees will have the opportunity to participate in up to four workshops, selecting from six distinct sessions that cover various therapeutic approaches: DBT, SFT, TFP, MBT, CBT, and GIT-PD.

For more information and to register for the event, please visit the ESSPD Workshops page (follow link here).

# MARCH NEWS

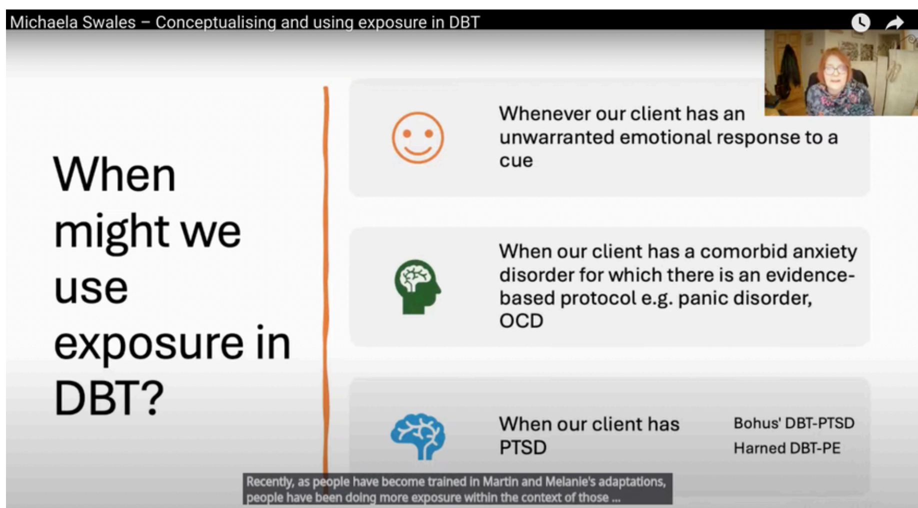
## WEBINAR RECAP: CONCEPTUALIZING AND USING EXPOSURE IN DBT

Michaela Swales' webinar, "Conceptualizing and Using Exposure in DBT," emphasized the underutilization of exposure in DBT, despite it being one of the four key change procedures. Research shows that only 4% of DBT sessions involve exposure, leading Swales to highlight its crucial role in helping clients regulate emotions and overcome avoidance. *"It's one of the four change procedures in DBT, but we know it's the one that's underutilized,"* she noted. Swales traced exposure's historical importance in DBT, recalling that Marsha Linehan once saw it as central to the approach. *"There was a phase that she went through where she talked about DBT as being all about exposure... and I think we've perhaps lost that a little bit."* Despite its proven effectiveness in CBT, its absence in DBT practice may hinder client progress. *"We know generally about exposure outside of DBT—it is one of the most effective cognitive behavioral strategies."*

She outlined three main situations where exposure is beneficial in DBT and discussed common therapist barriers to using exposure, such as uncertainty about when and how to implement it, or fear of causing distress. She reassured that exposure is not retraumatizing when applied correctly and that avoiding it may be counterproductive. "*You are not re-traumatizing anyone if you are presenting them with a cue that happened in their behavioral chain this week that led to an intense emotion.*" Exposure follows classical conditioning principles, requiring clients to face distressing stimuli while blocking avoidance behaviors. Using clinical examples, Swales illustrated how exposure can help clients, including those who avoid filling out diary cards due to shame or struggle with receiving feedback. A role-play exercise demonstrated how exposure could help a client experiencing distress after a friend cancels plans.

To address therapist hesitations, she encouraged self-reflection, practicing exposure within DBT consultation teams, and recognizing that discomfort is a natural part of effective treatment. *"If you're not using [exposure], you're kind of, in a way, hampering your efforts with your clients."*

**Key takeaway: Exposure is a powerful, evidence-based DBT tool that should not be overlooked.**



# TARGETING SELF-HARMING BEHAVIOUR WITH CLIENTS IN DBT

APRIL 6TH, 7 P.M. CET, GO TO LIVE STREAM HERE!!!

## Prof. Lars Mehlum

Lars Mehlum is a professor of psychiatry and suicidology and director of the National Centre for Suicide Research and Prevention at the University of Oslo, Norway. His work focuses on suicide research, prevention, psychotherapy, and personality disorders. His path into DBT was driven by a need for stronger evidence-based treatments for young people struggling with suicidal and self-harming behaviors. *"The adolescent adaptation of DBT was at the time a very good candidate for showing such evidence, but there had yet not been carried out any randomized trials. So I decided to conduct the very first RCT of DBT-A and this was the beginning of the story."* Beyond research, Mehlum is committed to bringing DBT into practice. Over 15 years, he helped implement DBT in every hospital and region in Norway. *"I know this makes a huge difference in so many people's lives—that they have access to evidence-based and compassionate care."* He also played a key role in changing Norway's gun ownership laws to require safe storage, a move that *"still saves hundreds of young lives in Norway every year."* As a researcher, clinician, and leader of a 40-person team, Mehlum believes in the power of working together to achieve real change. *"We can achieve the most incredible results if we join forces and work together."*

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In the upcoming webinar "Targeting self-harming behaviour with clients in DBT" I will first briefly review what are the underlying mechanisms of self-harming behaviour, particularly in people with BPD as a basis for discussing what strategies in DBT are most effective and useful when specifically treating this type of behaviour. We will discuss some common pitfalls and how to avoid them, how to balance between acceptance and change and still maintain adequate levels of patient safety, and we will address the extremely important objective of how to treat hopelessness.

# COUNTRY INTRODUCTIONS

## France

The idea to launch a French-speaking DBT association was born during the DBT-PTSD training that Martin Bohus delivered online in 2021 to a French-speaking public. We had initially planned to deliver the training in Paris – Martin was excited with the idea – but COVID stopped us. Following the training, Martin said that he supported our idea to launch an association. Blessed by one of the best, we felt empowered to give it a try. Given the huge needs in terms of DBT dissemination in France, and the close links between French-speaking clinicians in Switzerland and France, we knew from the beginning that our association would include France, Switzerland, and other French-speaking countries willing to join us.

### Plans for the future

We plan to continue providing support, training and encouragement to French-speaking clinicians. To this aim, we hope to rely on the work of the EDBTA to be able to have clear criteria for trainers and adherent DBT-clinicians. We also hope to expand, as we still have few clinicians from French-speaking Belgium and North Africa who are involved in the association.

### 100 MEMBERS

Our association is transnational, as it includes French-speaking clinicians in France, Québec, Switzerland, and Belgium. This is why we have two presidents from two different countries: Luisa Weiner (France) and Ueli Kramer (Switzerland), and one person on the board who is from the province of Quebec (Hélène Poitras). At the moment, we count over 100 people among our members. Most of them are psychiatrists and psychologists, but there are also occupational therapists, and nurses.

### Current challenges

- Accreditation of trainers and DBT clinicians in French language
- Dissemination of training

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

We can give French language materials, experience on transnational collaborations We need: expertise on how to structure training and accreditation in French-speaking countries

### How is training organized?

The association itself does not deliver trainings. In Québec, Hélène Poitras is a trainer affiliated with BehavioralTech Institute and owned a company providing a whole scope of DBT training in French. In France, Luisa Weiner and Sébastien Weibel provide 10-day trainings in the context of a University curriculum led by both of them. In Switzerland, training has been offered for over 20 years and will be formalized in the context of a University curriculum led by Ueli Kramer, Nader Perroud and Florence Guénot.

### Which advice would you like to give to others based on your national experience?

Working transnationally makes sense, as the linguistic needs are similar. Moreover, it may provide emulation and help consider cultural specificities.

# COUNTRY INTRODUCTIONS

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## France

### Active local therapy programmes

- **French-part of Switzerland (Geneva, Lausanne, Fribourg)**

For the past 20+ years, and after a foundational training organized with Marsha Linehan in Geneva and the publication of the translations of her book in French, the French-part of Switzerland has featured several active groups in DBT. Collegial links were maintained over the years, but only after the publication of the first RCT in 2016, a formal interest group was formed encompassing the three main University centers and hospitals, and colleagues in private practice. Since then, we have been organizing high-level training, by inviting Shelley McMain, Lars Mehlum, Wies Van den Bosch, Alan Fruzzetti and others to Lausanne in the context of the GIR-TCD (regional interest group for the support of DBT). These activities boost the expertise in the three clinical DBT programs and support development of new areas of expertise and research (DBT in adolescence, ADHD, antisocial behavior, addiction and so forth). The inter-University training curriculum in DBT (19 days) about to start in 2026, under the lead of Ueli Kramer, Nader Perroud and Florence Guénot is another example of the fruitful collaboration.

- **Strasbourg, France**

We provide comprehensive DBT, DBT-PE and DBT-PTSD to stage 1 clients. Our outpatient program has a minimal duration of 6-months. The team includes clinical psychologists, psychiatrists, nurses, a peer with lived experience and an occupational therapist. The funding was acquired via the Fonds d'Innovation Organisationnelle en Psychiatrie (FIOP). The team leaders are Luisa Weiner and Sébastien Weibel.

- **Province of Québec, Canada**

Hélène Poitras, trainer with BehavioralTech Institute, founded TCD Québec, an organisation dedicated to providing DBT training in French to clinicians. Across the province of Quebec, many teams are providing comprehensive DBT and some are providing DBT-PE or DBT-PTSD. In addition, some teams are providing DBT Skills groups as a primary DBT intervention. In the context of the national mandate for the organisation of public mental health services in Quebec, DBT is playing an important role in the dissemination of services for people with personality disorders. Collaboration with the French-speaking DBT association enables us to work together to disseminate French-language training in DBT.

https://reseau-francophone-tcd.com/

# COUNTRY INTRODUCTIONS

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## Czechia

The first DBT center in Czechia was established in 2008 within the therapeutic community Kaleidoskop near Prague. In 2019, the country's first healthcare-based DBT program was launched at the University Hospital Brno. Interestingly, the team leaders—Renata Tumlířová (Kaleidoskop) and Pavla Horká Linhartová (University Hospital Brno)—were unaware of each other's work until they met in 2018 at a DBT skills training course in the UK. Since then, we have been building a Czech DBT community. In 2022, a third comprehensive program, led by intensively trained therapists, was established at the Child Psychiatric Hospital in Opařany. It has become increasingly clear that the number of patients with BPD is rising rapidly in clinical care. There is both a growing demand for specialized treatments and significant interest among professionals in training for effective BPD treatment strategies. Since 2023, a national operational project led by the National Institute of Mental Health (NIMH) of Czechia has been in place, with members of our DBT section serving as professional guarantors and methodologists. This project has facilitated the establishment of several new DBT programs across the country (NIMH Prague, Klatovy, Mladá Boleslav, and Plzeň) and has supported the wider dissemination of DBT in Czechia.

### Which advice would you like to give to others based on your national experience?

We believe communication and cooperation are key. Working in diverse settings, we use dialectical thinking to enrich one another. In Czechia, DBT relies on departmental leaders' support, and we must unite our efforts to make DBT more accessible to patients in need.

## 32 MEMBERS

Our association operates as the DBT section under the Czech CBT Association. Established in June 2023, it was formed by DBT therapists from the three DBT program led by intensively trained DBT therapists in Czechia. We currently have 32 members, primarily psychologists, psychiatrists, and social workers. The section is led by Pavla Horká Linhartová, with Zuzana Koubková and Tereza Šmejcká serving as co-leaders, each representing a DBT site. In 2024, several new DBT programs were launched in Czechia, and we actively invite new DBT therapists to join. We anticipate significant growth in membership throughout 2025.

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

We are a small organization that integrates DBT in various contexts: outpatient, inpatient, and community-based settings, for both adults and adolescents. We are eager to share our experiences in implementing DBT across different environments and collaborate on international research studies. What we need is international support for DBT implementation and training in Czechia.

### Do you involve people with lived experience?

We have not involved people with lived experience in our DBT section so far. Some of the DBT teams in Czechia, however, do have a peer consultant as a team member, and the national operation program for DBT implementation invites peer experts in expert platforms.

# COUNTRY INTRODUCTIONS

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## Czechia

### Active local therapy programmes

- **University Hospital Brno**

The DBT program at University Hospital Brno was established in 2019 as the first healthcare-based and second overall DBT program in Czechia. We offer a six-month outpatient program, including two skills training sessions and one individual therapy session per week. Fully covered by insurance, the program still has a two-year waitlist. In 2024, we doubled capacity to two groups of 10 patients each (we have over 90 absolvents). Additionally, we provide a four-week inpatient DBT program. Our team consists of 11 intensively trained members.

- **Kaleidoskop**

The Kaleidoskop Center operates three DBT programs within social services. The therapeutic community (since 2006) integrates DBT with programs lasting 4–18 months. The DBT Center for Adults in Prague (since 2015) runs four concurrent groups, while the DBT Day Program for Adolescents (since 2021) offers seven multi-family and one adolescent-only group. We also run three online DBT groups and launched "DBT in Schools" in 2024. Kaleidoskop's 30-therapist team supports 130 free-service clients and 50 in paid programs.

- **Opařany**

The DBT program at the Children's Psychiatric Hospital in Opařany (est. 2022) is Czechia's first healthcare inpatient DBT program for adolescents (14–17 years). The 7–8-week D-BOAT (Dialectical Behavioral Opařany Adolescent Therapy) program includes daily skills training, weekly individual therapy and parent groups. Fully covered by insurance, it has served 150 adolescents and families. Our team consists of 11 intensively trained therapists.

ČESKÁ SPOLEČNOST KBT

DBT sekce

### Current challenges

- **Standards and Professions**

The number of professionals implementing DBT elements in Czechia is steadily growing. While we support the integration of DBT elements into various practices, we emphasize the importance of distinguishing these from a full, complex DBT program, which should be led by trained therapists. DBT in Czechia is delivered by various professionals across different settings (outpatient, inpatient, and community), which we consider our strength, and it also makes defining DBT standards and establishing certification processes challenging.

- **Translations**

Until recently, no official translations of DBT literature were available in Czech. Our DBT section has worked to create a unified Czech nomenclature and translated some handouts and worksheets for therapeutic use. Currently, we are collaborating with a national publisher on an official translation. Our goal is to ensure that the official Czech translations are of high quality and aligned with our unified nomenclature.

- **Increasing Availability**

DBT is gaining increasing interest in Czechia, with many professionals implementing its elements. As the Czech DBT section, we aim to bring these practitioners together to form a collaborative and productive community. However, waiting times for DBT programs across the country are excessively long (ranging from months to years). To meet the growing demand and provide effective treatment, we must increase the availability of DBT services to support our patients better.

# RESEARCH DIGEST

## Mapping Dialectical Behavior Therapy Skills to Clinical Domains Implicated in Contemporary Addiction Research: A Conceptual Synthesis and Promise for Precision Medicine

Luk and Thompson, https://doi.org/10.1016/j.cbpra.2024.07.002

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ScienceDirect

Cognitive and Behavioral Practice

**Mapping Dialectical Behavior Therapy Skills to Clinical Domains Implicated in Contemporary Addiction Research: A Conceptual Synthesis and Promise for Precision Medicine**

Jeremy W. Luk, *Office of the Clinical Director, National Institute on Alcohol Abuse and Alcoholism*
Matthew F. Thompson, *Office of the Clinical Director, National Institute on Alcohol Abuse and Alcoholism, Uniformed Services University, and The Warren Alpert Medical School of Brown University*

There are several clinical studies supporting the effectiveness of Dialectical behavior therapy (DBT) in treating substance use disorders (SUD) (Linehan et al 1999, Linehan et al. 2002, Leet et al., 2018, Pennay et al., 2011.). For example in their RCT from 1999 Linehan and colleagues showed that patients with borderline personality disorder (BPD) and comorbid SUD benefited more in terms of global and social adjustment if they received DBT over a period of 12 months and at the 16 month follow up. They also had longer periods of abstinence than participants in the TAU group. SUD and BPD share underlying common characteristics such as emotion dysregulation and impulsivity.

In this publication, the authors explain how DBT skills might be chosen and applied to a specific client with SUD depending on the dominating mechanism of problem behavior. Their approach is based on the so-called Addictions Neuroclinical Assessment. In this framework, development, maintenance and progression of Alcohol use disorder is seen as based on three functional domains: Executive dysfunction, incentive salience and negative emotionality. These postulations are based on the addiction cycle model, which assumes that specific brain regions change during the three stages of addiction: binge/intoxication (basal ganglia), withdrawal/negative affect (extended amygdala), and preoccupation/anticipation (prefrontal cortex), (Koob & Moal, 1997; Koob & Volkow, 2016).

Depending on the individual's major deficits and challenges, skills training might be tailored, choosing skills directed at the dominating functional domain (Executive dysfunction, incentive salience and negative emotionality). Such proposals have already been made concerning medication (using naltrexone to target reward-driven drinking (incentive salience) and acamprosate to target relief-driven drinking (negative emotionality).

The article provides a guide for clinicians to choose which skills to prioritize seeking to shorten therapy and increase accessibility. Mindfulness skills are regarded as a foundation for all clients. If there is a marked difficulty with inhibitory control, shifting attention from addiction-related cues, and making decisions in line with goals (executive functions), a clinician might focus more on skills such as Dialectical abstinence, Clear mind as well as Remembering pros and cons for resisting urges. However if struggles with urges and cravings and automated behaviors are predominant (incentive salience), the authors suggest teaching skills such as Burning bridges and building new ones, TIPP, and STOP. Negative emotionality might require a focus on Checking the facts, Opposite action and Radical acceptance (these skills are described in detail in M. Linehan's DBT Skills Training Manual, Second edition, 2015).

Continuing on the next page...

# RESEARCH DIGEST

There are also three case vignettes to illustrate matching skills to an individual profile. We have chose to include the first one here as a direct citation:

*"A white bisexual woman in her early 20s reports increased binge drinking episodes that are driven and maintained by elevations of incentive salience and negative emotionality in the context of minority stressors and declining academic performance. Given that she drinks socially on weekends, Burn Bridges & Build New Ones can help her reduce social drinking and identify alternative ways to manage her cravings (e.g., urge surfing). To target the loss-of-control drinking, she can use the STOP skill as a basic strategy to increase awareness of her internal thoughts/feelings as well as external triggers. Through observing and proceeding mindfully, she can make decisions in her Wise Mind while remembering what her goals are in the situation. On top of that, the TIP skills offer several options to help address intense emotions that trigger binge drinking and intoxication. Finally, Opposite Action can be used to reduce shame related to her prior sexual experiences and help address self-stigma (e.g., sharing her experiences in LGBTQ [Lesbian, Gay, Bisexual, Transgender, and Queer] friendly support groups)."*

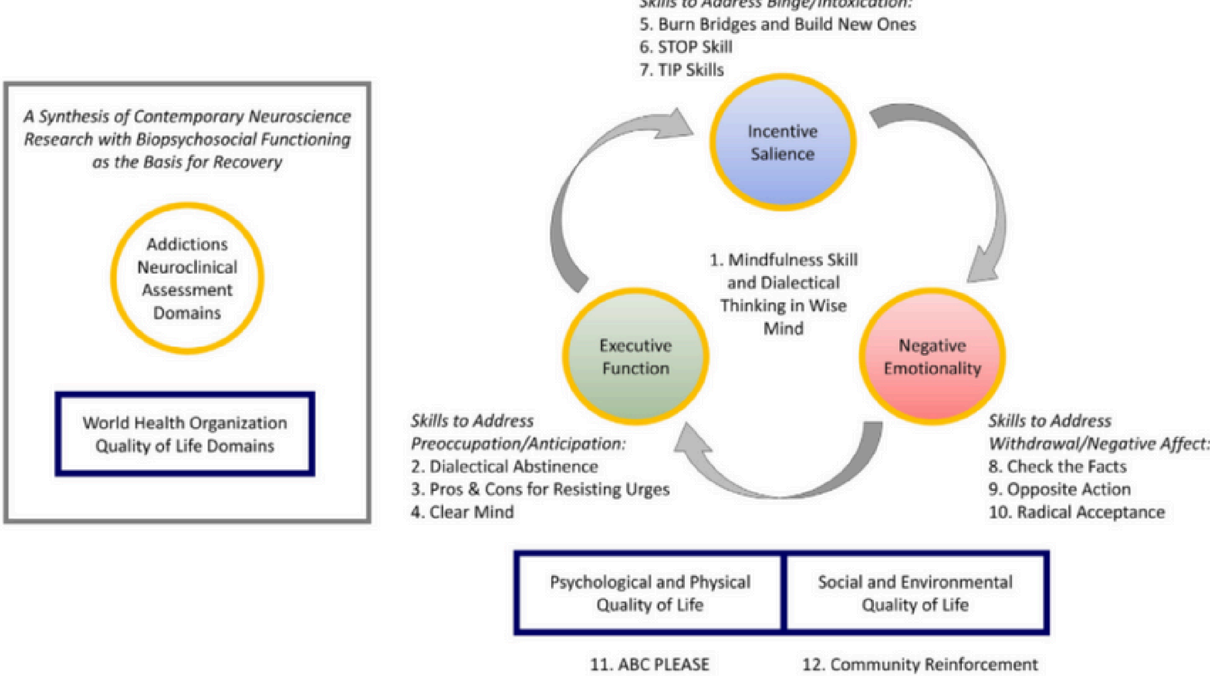
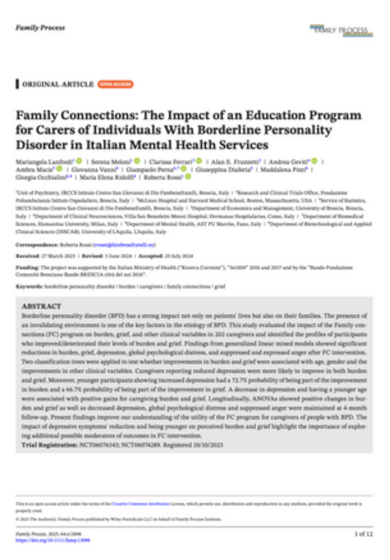



**Figure 1.** Conceptual Synthesis of DBT Skills and Clinical Domains Implicated in Contemporary Addiction Research

# RESEARCH DIGEST

## Family Connections: The Impact of an Education Program for Carers of Individuals With Borderline Personality Disorder in Italian Mental Health Services

Mariangela Lanfredi, Serena Meloni, Clarissa Ferrari, Alan E. Fruzzetti, Andrea Geviti, Ambra Macis, Giovanna Vanni, Giampaolo Perna, Giuseppina Diaferia, Maddalena Pinti, Giorgia Occhialini, Maria Elena Ridolfi, Roberta Rossi. Fam Process. 2025 Mar; 64(1): e13098. Published online 2025 Jan 28. doi: 10.1111/famp.13098


Family Process

ORIGINAL ARTICLE OPEN ACCESS

**Family Connections: The Impact of an Education Program for Carers of Individuals With Borderline Personality Disorder in Italian Mental Health Services**

Mariangela Lanfredi | Serena Meloni | Clarissa Ferrari | Alan E. Fruzzetti | Andrea Geviti | Ambra Macis | Giovanna Vanni | Giampaolo Perna | Giuseppina Diaferia | Maddalena Pinti | Giorgia Occhialini | Maria Elena Ridolfi | Roberta Rossi

**ABSTRACT**
Borderline personality disorder (BPD) has a strong impact not only on patients' lives but also on their families. The presence of an invalidating environment is one of the key factors in the etiology of BPD. This study evaluated the impact of the Family Connections (FC) program on burden, grief, and other clinical variables in 202 caregivers and identified the profiles of participants who improved/deteriorated their levels of burden and grief. Findings from generalized linear mixed models showed significant reductions in burden, grief, depression, global psychological distress, and suppressed and expressed anger after FC intervention. Two classification trees were applied to test whether improvements in burden and grief were associated with age, gender and the improvements in other clinical variables. Caregivers reporting reduced depression were more likely to improve in both burden and grief. Moreover, younger participants showing increased depression had a 72.7% probability of being part of the improvement in burden and a 66.7% probability of being part of the improvement in grief. A decrease in depression and having a younger age were associated with positive gains for caregiving burden and grief. Longitudinally, ANOVAs showed positive changes in burden and grief as well as decreased depression, global psychological distress and suppressed anger were maintained at 4-month follow-up. Present findings improve our understanding of the utility of the FC program for caregivers of people with BPD. The impact of depressive symptoms' reduction and being younger on perceived burden and grief highlight the importance of exploring additional possible moderators of outcomes in FC intervention.
**Trial Registration:** NCT06076343; NCT06074289. Registered 10/10/2023

1 of 12

**This study** evaluates the effectiveness of the Family Connections (FC) program in supporting caregivers of individuals with Borderline Personality Disorder (BPD) within Italian mental health services. The FC program is a 12-week educational intervention designed to provide caregivers with information about BPD and teach emotion regulation skills. A more in depth description of the programme can be found in the February issue of this EDBTA newsletter (interview at the end).

The naturalistic single-arm study involved 202 family members (74.2% were parents, 9.9% partners of individuals with a diagnosis of BPD) participating in the FC program across various Italian mental health services. They were assessed three times: at baseline, after the 12-week program and after a follow-up period of 4 months. 202 participants completed the first two assessments (mean age was 53,2 years , 60,9% of participants were females, 39.1% were males), 123 participants completed all three assessments.

**Key Findings:**

- Burden Reduction: Caregivers reported a significant decrease in perceived burden following the program according to the Burden Assessment Scale (BAS, time coefficient from pre to post intervention was =-0,29).
- Grief Alleviation: There was a significant reduction in feelings of grief among caregivers based on the Grief Scale (GF, time coeffcient from pre to post intervention was =-0,35).
- Significant improvements were also found for depression symptoms (BDI-II), SCL-90 (reflecting psychopathology symptoms) and anger expression measured by STAXI-2 ER/IN from pre to post intervention.
- These results were maintained at 4 months follow up.
- Younger age of participants was associated with positive gains for caregiving burden and grief.

**Limitations:**

- The study's observational nature limits the ability to establish causality between the FC program and observed improvements.
- Without a control group, it's challenging to attribute the improvements solely to the FC program.
- Data was acquired solely from Self-Reported Measures, only 123 out of 202 participants completed the follow up assessment.

# RESEARCH DIGEST

## Can dialectical behavior therapy skills group treat social anxiety disorder? A brief integrative review

Villalongo Andino, M., Garcia, K. M., & Richey, J. A. (2024). Frontiers in Psychology, 14, Article 1331200. Segal O, Bronshtein K, Weinbach N. (2025). Current Psychology. 1-13. 10.1007/s12144-025-07286-0.

This integrative review examines whether DBT Skills Group (DBT-SG) can be an effective intervention for Social Anxiety Disorder (SAD), particularly for individuals with suicidal ideation (SI). The article evaluates current evidence and explores how DBT skills - interpersonal effectiveness, mindfulness, emotion regulation, and distress tolerance - may target key maintenance factors of SAD. Authors reviewed existing research on DBT-SG and analyzed mechanisms within SAD that may be targeted in DBT-SG.

**Interpersonal Effectiveness** might reduce social avoidance and improve self-perceived competence. DEAR MAN provides a structured communication strategy for effective self-expression while maintaining self-respect. It might help balance relationships, reducing people-pleasing or withdrawal. Additionally, it could challenge distorted social beliefs, encouraging gradual exposure to build confidence. For example, DEAR MAN might help someone express disagreement instead of avoiding confrontation.

**Mindfulness** might lower self-focused attention and negative rumination. It encourages present-moment awareness, reducing self-focus and mental replay of social events. It also promotes non-judgmental observation, allowing individuals to detach from anxious thoughts rather than over-identify with them. For example, “Observe and Describe” might help someone recognize anxious thoughts without reacting negatively.

**Emotion Regulation** might help modify maladaptive emotional responses. SAD often triggers strong emotional reactions, leading to avoidance or suppression. Many rely on over-apologizing, withdrawing, or self-criticism to cope with perceived social failure. Opposite Action encourages individuals to face rather than avoid anxiety-provoking situations, reducing fear responses. It might also help label and reframe emotions, reinforcing that social discomfort is temporary and manageable.

**Distress Tolerance** might provide strategies for managing social anxiety without avoidance. People with SAD often have low distress tolerance, leading to avoidance or excessive preparation. Many rely on safety behaviors (e.g., using a phone to avoid eye contact) instead of building internal coping skills. Crisis survival strategies like breathing techniques and distraction might help reduce anxiety intensity. Reality Acceptance could teach that anxiety is uncomfortable but not harmful, allowing individuals to stay in social situations rather than escape. For example, TIP skills might help regulate anxiety before public speaking.

**Limitations**

- There is no direct research on DBT-SG for SAD—no RCTs or systematic studies have tested its effectiveness for this population. Findings may not generalize to adolescents or elderly individuals, where suicidal ideation rates are high. Additionally, it is unclear how different severities of SAD—especially cases without suicidality—respond to DBT-SG.
- While DBT-SG could be a promising alternative for SAD, particularly for individuals with suicidal ideation and comorbid conditions, further research is necessary.

# RESEARCH DIGEST

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## [“You sure she's not making this up?”: A qualitative investigation of stigma toward adults with borderline personality disorder in physical healthcare settings]

Navarre, K. M. (2025). Personality and Mental Health, 19, e1646. doi: 10.1002/pmh.1646

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RESEARCH ARTICLE

**“You sure she's not making this up?”: A qualitative investigation of stigma toward adults with borderline personality disorder in physical healthcare settings**

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**Abstract**
Borderline personality disorder (BPD) is associated with pervasive stigma that contributes to several consequences, such as inaccessible and inadequate healthcare. Existing literature concerning the experiences of BPD stigma within healthcare settings predominantly centers on mental healthcare contexts. However, individuals with BPD also present with elevated physical disabilities and health concerns, demonstrating a need for regular contact with medical professionals to manage and coordinate physical healthcare. The current qualitative study analyzes the dynamics of stigma and consequences in medical settings for physical healthcare among individuals diagnosed with BPD. Community adults ($N = 16$, $M_{age} = 29.50$, 44% cisgender women) provided qualitative responses describing their experiences with stigma in medical settings other than for mental health purposes. The inductive thematic analysis generated six key themes: (1) Dismissal and Misattribution of Physical Symptoms, (2) Delayed or Inappropriate Medical Diagnosis and Intervention, (3) Communication and Advocacy Challenges, (4) Invalidation of Emotional Well-Being and Distress, (5) Self-Harm Stigma, and (6) Presumed Drug-Seeking Behavior. This article demonstrates the persistent and complex role of stigma across physical healthcare settings for individuals with BPD, affecting their physical and mental healthcare outcomes. It also identifies areas for future research and improvement and offers insights to ameliorate these issues.

**INTRODUCTION**

While stigma affects all psychological disorders, the stigma associated with borderline personality disorder (BPD) is exceptionally pervasive and challenging. Research suggests that BPD may be more stigmatized than other highly stigmatized psychological disorders, including other personality disorders and schizophrenia (Markham, 2003; Markham & Trower, 2003; Masland & Null, 2022; Sheehan et al., 2016). Clinicians may misconstrue individuals with BPD as having more control over their behaviors compared to people with other psychological disorders, thus perceiving their difficulties as a personal failing or deliberate misbehavior (Sheehan

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**This study:**
BPD is highly stigmatized, often more so than other mental health conditions. While much research focuses on stigma within mental health settings, individuals with BPD also face significant barriers in physical healthcare due to misconceptions about their condition. This study explores how stigma affects their access to and experiences in medical settings beyond psychiatric care. The study used qualitative thematic analysis to examine responses from 16 adults with BPD (mean age 29.5), recruited from a larger study on lived experiences. Participants completed an online survey describing their encounters with stigma in medical settings unrelated to mental health treatment.

**Key Findings**

- Symptoms were frequently dismissed as anxiety or psychosomatic rather than being taken seriously, often being told their symptoms were "all in their head." This misattribution led to missed diagnoses and unnecessary suffering, as individuals were not given proper medical tests or treatment.
- Many participants reported that medical issues were overlooked, leading to delayed or incorrect treatment. The stigma resulted in increased mistrust toward medical providers, making some individuals hesitant to seek medical help in the future.
- Healthcare providers often questioned third parties instead of speaking directly to patients, reinforcing feelings of disempowerment. This led to a sense of frustration and isolation, as individuals with BPD felt unheard and excluded from decisions about their own care.
- Emotional distress was often downplayed, with patients being labeled as overly sensitive or exaggerating their symptoms. Many participants reported being told they were "overreacting" or "seeking attention," which discouraged them from expressing distress in future medical encounters.
- Medical professionals sometimes neglected or dismissed self-inflicted injuries, failing to provide proper assessment or care. Some individuals were denied pain relief or wound care, with medical staff assuming their self-harm was an attention-seeking behavior rather than a medical concern.
- Participants reported being treated with suspicion when requesting pain medication, reinforcing harmful stereotypes. Many shared stories of being denied pain management for legitimate conditions, with doctors assuming they were seeking opioids for misuse rather than treatment.

This study highlights how stigma in physical healthcare settings negatively impacts individuals with BPD, leading to misdiagnosis, treatment delays, and increased emotional distress. It underscores the need for greater education among medical professionals on BPD and its intersection with physical health to improve patient care. However, the study's small sample size and reliance on self-reported experiences may limit its generalizability. Future research should expand participant diversity, increase sample sizes, and examine structural factors that contribute to stigma in healthcare. Additionally, the study suggests that more research is needed to understand how stigma influences physical health disparities for individuals with BPD.

This section provides a space for members and those interested in DBT to explore and share therapy-related assumptions, theories, and concepts that may not necessarily reflect the official views of EDBTA. We warmly welcome these contributions as a way to encourage thoughtful discussion and exchange of ideas, and we are pleased to publish them as part of this ongoing dialogue.

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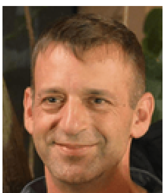

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## Life Worth Living Goals: Guiding Therapists and Clients to Define Meaningful Life Objectives in DBT

*Life Worth Living Goals (WLG) are a cornerstone of Dialectical Behavior Therapy, particularly in the pre-treatment phase. This phase focuses on fostering commitment and helping clients identify what makes life meaningful to them. The concept of WLG aligns closely with Viktor Frankl's logotherapy, which emphasizes the pursuit of meaning as a fundamental human motivator. Frankl believed that discovering meaning enables individuals to endure even significant suffering. Similarly, Steven Hayes, the developer of Acceptance and Commitment Therapy (ACT), has highlighted the importance of values exploration as a bridge to goal formulation—a perspective closely aligned with the principles Marsha Linehan introduced earlier in DBT.*

*Values play a pivotal role in fostering meaningful change. They are deeply held principles that define what truly matters to an individual, serving as a compass to guide their actions and decisions. Unlike fleeting emotions, values provide a stable and enduring source of motivation, helping individuals connect with a sense of purpose even when facing discomfort or adversity. By clarifying their values, individuals can identify goals that align with their authentic selves, making those goals more meaningful and achievable. This connection between values and goals creates a powerful link: values give individuals a "why" that sustains commitment to change, even when the journey becomes challenging. In this way, values exploration in ACT and DBT transforms abstract aspirations into concrete reasons to stay engaged and work toward a life worth living.*

*The process of defining WLG often brings emotional barriers to the surface, making it difficult for patients to articulate their aspirations. That can trigger old shame to emerge in the moment. Some clients struggle with feelings of inadequacy or embarrassment stemming from previous attempts at change that ended in failure. This shame can make them hesitant, sometimes leading to a full phobic-avoidant reaction that undermines the confidence needed to dream big or imagine a better future. Fear of expectation and disappointment may also play a role as a WLG inhibitor. For clients who associate hope with disappointment, the act of setting goals may evoke anxiety. They may regulate their emotions by intentionally lowering expectations, seeking to protect themselves from future letdowns. Another barrier may involve guilt about wanting more. Some clients may feel unworthy of striving for a better life, interpreting their desires for growth or happiness as "pretentious" or "unrealistic." These obstacles can leave clients feeling stuck, unable to leave the harbor of pre-treatment and venture into the open sea of stage one.*

*Therapists often struggle with determining the appropriate scale of WLG. How big or small should the dream be? A useful reference is Maslow's Hierarchy of Needs, which begins with foundational necessities and progresses toward self-actualization. Similarly, WLG starts with basic needs—such as safety, food, and shelter—and then moves to social and emotional needs, culminating in goals that align with self-actualization. By framing WLG in terms of this "common humanity" idea, therapists can help clients accept the logic and validity of addressing foundational issues first before pursuing higher-level aspirations.*

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*A powerful method for helping clients envision their WLG without overwhelming them is the Crystal Ball Technique, introduced by Christine Dunkley (Btech's blog February 2022). This technique uses guided visualization to encourage clients to imagine a future where their goals have been realized—not perfectly, but in a way that feels meaningful and worth the effort. The therapist acts as if a crystal ball sits on their desk. Spreading their arms, they start describing what they can see—a potential way the client may fulfill their goals. Importantly, the therapist demonstrates that hopes and plans can be expressed out loud, counteracting feelings of shame through an "opposite action." To ensure the vision feels collaborative, the therapist might say, "I see this, but is this you?" rather than asserting it as fact. This avoids creating a tug-of-war and keeps the client in control of their narrative.*

*For example, the therapist might say:*
*"I see you waking up in the morning in a space that feels safe and your own—a small house with a large yard, which looks like a rural area. I see dogs there; it looks like this is the training farm you started with a partner you met through your work. You're both in work clothes; he just annoyed you with something he didn't do after promising he would, but oh—he seems sorry. You accept him, flaws and all. Look, it seems like some people are arriving with puppies to train. It might rain soon, and you're rushing everyone into the barn. Hurry up, or you'll get wet!"*

*This snapshot creates a vivid yet grounded vision, reminding clients that life is not perfect but can still feel worth living. By avoiding emotionally overwhelming details, such as discussing deeply personal matters like pregnancy, therapists can prevent the vision from becoming too evocative or distracting. Instead, the emphasis remains on fostering hope and helping clients see manageable steps toward a meaningful life.*
*Using the first-person perspective ("I see..."), therapists can help clients overcome obstacles and nihilism. However, it is important to note that this approach may not be suitable if the client is experiencing significant anxiety about the future.*

*Life Worth Living Goals are not just theoretical constructs but essential tools for helping clients connect with a meaningful vision of their future. They serve as a window to their learning history and a place to contemplate a CBT-formulated intervention aimed at removing the barriers to committing to goals.*

# EDITORIAL

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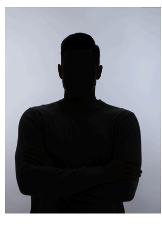

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## News gathered and generated by specific country officials

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