Europian Dialectical Behaviour Therapy Association

NEWSLETTER

#1 October 2024

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There is magic in every beginning!!!

As president of the newly founded European DBT Association (EDBTA), I feel a little proud and also happy that, I can write: You are holding the first newsletter of the EDBTA in your hands. The newsletter will appear monthly. It is originally written in English and should be translated into almost all European languages. New technologies and old dreams make this possible. This newsletter is a symbol, or better, a first concrete realization of the EDBTA's ideas: to create a platform on which DBT can develop and flourish, and on which those who are interested in it can enrich each other.
You all know that Dialectical Behaviour Therapy (DBT) has been established in recent decades as an effective treatment approach for various mental disorders, in particular for borderline personality disorder. It is scientifically well-proven, and in most European countries there are organizations that promote the dissemination of DBT. However, these processes are quite diverse. There are countries with over thousand trained and certified DBT therapists including well-established training systems, and there are countries where a few dedicated individuals are working to spread the first ideas of DBT. The former might benefit from expanding their contacts and knowledge across Europe, the different healthcare systems, and the various cultural aspects. The latter should benefit from the experience and materials of the highly developed DBT countries. For this purpose, a platform for the exchange of knowledge, research and best practices might be a driving force. The European DBT Association (EDBTA) was created for this very reason.

The EDBTA has several key objectives:
Networking: *By creating a European network, the EDBTA aims to promote interdisciplinary exchange between professionals, researchers and practitioners among Europe. This should help to further develop treatment methods and share experiences.*
Promoting training-guidelines: *The EDBTA is committed to create guidelines for high-quality training programs for therapists and professionals to ensure that DBT is applied according to the latest scientific standards.*
Research and development: *The EDBTA plans to support research projects that address the effectiveness and adaptability of DBT in different cultural and social contexts.*
Public relations: *Another goal of the EDBTA is to raise public awareness of mental illness and the importance of evidence-based therapy such as DBT. This should help to reduce stigma and promote acceptance of mental health.*

The official founding of the EDBTA took place online on October 16th 2023. At this event, professionals from various European countries gathered to discuss the vision and mission of the new organization. In addition, a charter was drafted that lays the foundation for membership and organizational structures. We decided that no individuals, but only national DBT associations can become members, and that the representatives of these associations form the decisive body: the general meeting of members.

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The General Membership Meeting elects a board of 5 up to 7 members, incl. the president, the secretary and the treasurer. The board will resign after three years. These are the normal requirements for articles of incorporation. The EDBTA is registered in Germany as a European non-for-profit organization. But these are only formalities. Like every organization, the EDBA depends on the commitment of its members, the national associations. They are the ones who do the work that we all benefit from. The EDBTA is an umbrella organization that aims to provide as much support and as little control as possible. This should also be reflected in the newsletters. The national organizations dominate here. Every time, two countries will introduce themselves and report on their very specific developments in DBT.

Why do we start with Poland? Not only because Magdalena Szuka, is from Poland and the most wonderful DBT secretary in the world, but also because the Polish DBT Association has agreed to organize the first European DBT Congress in Gdansk. This can be done quite casually by handing over the organization to a congress office. You pay a high price for this, and the participants take it on. But if we want to make the DBT Congress attractive to participants from low-income countries, we have to keep prices low and organize as much as possible ourselves. And that's what the Poles have decided to do, and for that they deserve a place of honor in the newsletter. The second country to introduce itself is Ukraine. You can imagine why. We all know that the country has been fighting a terrible defensive war for over two years, and that it needs all the support we can give it. And the fact that DBT is being built and developed under all these circumstances is more than remarkable.

DBT is based on clear principles and rules, but it is never static. Rather, it is subject to a gentle but increasing process of change. To do this, it is certainly helpful to be continuously updated on the most important research findings in the field of DBT, borderline disorder and associated disorders. That is why we have invented the 'Research Digest' section. Here you will find extended abstracts of the most interesting publications that relate to our work. But ultimately, it is always about our clients being offered the best possible clinical practice. In the 'Practitioners Corner' section, clinical practice is not pushed into the corner but is at the center of the discussion.

A big thank you to our two authors, Romija Krezina and Jan Hilbig, for their great work. They will certainly appreciate every single response and contribution.

On that note, on behalf of all members of the EDBTA board, we would like to launch this newsletter and wish it a long life.

Prof. Martin Bohus, MD
President EDBTA

OCTOBER NEWS

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The European DBT Association (EDBTA) is pleased to announce that the inaugural European DBT Congress will take place from May 8th to 10th 2025 in the beautiful city of Gdansk, Poland. The Polish Association for DBT (PTDBT) will be our esteemed co-host. We extend a warm invitation to all DBT community members from Europe and beyond, both experienced colleagues and newcomers, to join us for a truly international scientific programme, full of seminars, workshops and exchange of ideas, matched with Polish hospitality and great networking. The congress will be conducted in a hybrid format, with all plenary lectures and a selection of parallel sessions made available online. The congress will feature leading experts in the field, including Julieta Azavedo (Portugal), Martin Bohus (Germany), Ausias Cebolla (Spain), Alan Fruzzetti (USA), Lars Mehlum (Norway), Magdalena Skuza (Poland), and Michaela Swales (UK). The program will commence with a pre-congress workshop and opening ceremonies on May 8th, followed by plenary talks and networking at "The Grand Bazar," and will conclude with a welcome reception. On May 9th, the conference will offer plenary sessions, parallel seminars, and a networking party with live music. The final day, May 10th, will include further parallel sessions and closing remarks, culminating in a post-congress workshop. Key workshops include DBT for children and families, substance use, autism spectrum disorders, perinatal care, trauma-focused DBT, forensic care, and DBT Tango! The conference offers a comprehensive platform for discussing the latest advancements in DBT and their diverse applications.

More information on the congress can be found here.

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COUNTRY INTRODUCTIONS

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Poland

During the ESSPD Borderline Congress in Vienna in September 2016, many representatives of DBT communities from European countries met to discuss the formation of a society for DBT in Europe. Two enthusiastic therapists from Poland were invited to the meeting and they were speechless to see so many world-renowned DBT experts in one room. While listening to Prof. Martin Bohus presenting the plans of the would-be European DBT associations and the model for developing the DBT network across Europe, with the training, supervision and implementation schema they were captured by the idea. There were only two of them from Poland at the Congress, but they were strongly motivated to form the national association as soon as possible in order to be able to join the European DBT society, which they believed was at that time in the process of being formed. After returning home they formed the initial group of members and in 3 months the Polish Association for DBT was officially registered in the court, in December 2016 in Gdańsk. In the following years the Polish Association for DBT grew to more than 200 full members and many affiliates, organised several conferences, seminars and trainings and helped to promote DBT in various institutions. And 7 years later, in 2023, one of the very first members, who was amazed by Martin Bohus and others' vision of a European DBT network in 2016, became one of the founding members of the actual European DBT Association and in 2025 Poland is going to host the 1st European DBT Congress in the beautiful city of Gdansk.

400 Members

The Polish Association for Dialectical Behavioural Therapy was founded in December 2016. Our Association has more than 400 regular members and additional supporting members. Most of our ordinary members are psychologists and psychotherapists, while the supporting members are mainly patients and their relatives, non-proffesional Family Connections leaders and supporters of DBT therapy. At present, the Board of the Association consists of five members: Magdalena Skuza (President of the Board), Anna Englert-Bator, Ph.D. (Vice-President), Joanna Wiatr-Abramowska (Treasurer), Katarzyna Sikora, Ph.D. (Secretary), Magdalena Muracka-Tylko (Member of the Board).

How is training organized?

From 2020, we have been organising an annual DBT Comprehensive Training with Prof. Alan Fuzzetti and the local training team. This annual training consists of 12 training days in 4 parts. The training is conducted in a team format, if participants come to the training alone, we would organise them into teams. In between the training sessions, the participants work in the teams with their weekly consultation meeting and the local mentor supervises their work on a monthly basis. To conclude the training, participants must complete their individual homework (including the case formulation) and their group homework.

Who is in charge?

Magdalena Skuza
President of the Board

Anna Englert-Bator
Vice-President

COUNTRY INTRODUCTIONS

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Poland

Advice for others

As Marsha Linehan said, never give up on your goals. The most important thing in developing DBT in your country is to work together as a team and encourage more people to get involved. It is worth networking with colleagues from abroad who can support us, especially in the early stages. And this will be easier if you remember that DBT therapists can always be counted on to follow the same principles and skills that they teach their patients: to be validating, to be wise and to do what works. And have fun doing it!

Current challenges

- Our public mental health system does not promote evidence-based therapies (and therapists) over other treatments, so there are no incentives for agencies to put effort into implementing programs like DBT at the regional or national level.
- Our trainings have produced significant numbers of DBT therapists, but we still have very few consistent DBT treatment programmes nationwide.

Active local therapy programmes

- Most DBT programmes have to be set up in private practice (in private mental health clinics or from the group of private practices). This is due to the limitations of our public mental health system. We have comprehensive outpatient DBT programmes for both adults and adolescents, but they are available locally, not nationally.
- Within the public sector, there are 3 well-known institutions that offer comprehensive DBT programmes: a public hospital in Warsaw that offers a comprehensive DBT programme for adults, a public clinic in Krakow that offers the DBT daily treatment programme for adolescents, and a programme for a substance use and addiction treatment centre in Nowy Dworek. There are other public institutions that are slowly starting to offer elements of DBT - mostly skills groups outside of a comprehensive programme. However, this development is due to the motivation and persistence of individual therapists rather than systemic change.
- We would like to shed some light on the Family Connections programme, a free 12-week psychoeducational family intervention developed on the basis of DBT. Family Connections has grown in Poland as an intervention independent of the DBT programme (although it shares the same principles and skills).Our association develops the FC programme in close cooperation with the National Alliance for BPD, USA, and its growth in Poland is possible thanks to the commitment and hard work of volunteers who teach and coordinate the programme. Family Connections is offered throughout the country in both private and public institutions.

FAMILY education - skills - support CONNECTIONS™ NEA BPD

Plans for the future

Our immediate plans are to implement a system of training, certification and supervision of DBT teams according to EDBTA standards. We also want to support individual therapists in forming DBT teams and running sustainable DBT programmes. We will also continuously develop the Family Connections programme, without which we cannot imagine DBT in Poland. We also plan to develop specialised DBT programmes - for children, adolescents and families, as well as trauma-focused DBT therapy. To this end, we are inviting experts to train in our country and will then monitor the programmes that we hope will emerge. We would also like to start research on DBT in our country and are open to cooperation with others in this field.

P·T·D·B·T
POLSKIE TOWARZYSTWO TERAPII DIALEKTYCZNO BEHAWIORALNEJ

COUNTRY INTRODUCTIONS

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Ukraine

A significant event that marked the beginning of DBT development in Ukraine was the conference in 2016 with Martin Bohus introducing DBT to Ukrainians. The first program (classical training for specialists) was held in Odessa, the leading trainer was Ukrainian-born Tetyana Reinhardt, who lives in Germany and works in prof. Martin's team. Since then, the German institute AWP Freiburg and our DBT Center Ukraine in joint cooperation conduct a one-year training course for new therapists in Ukraine every year. In 2019, the first two Ukrainian therapists were accredited. They are now studying further to become DBT trainers, participating in the training as co-trainers. We hope that there will be accredited Ukrainian-speaking trainers and supervisors in Ukraine, as teaching through translation carries its own difficulties and additional financial burden. Despite all the difficulties of the war, DBT is flourishing in Ukraine. We are grateful to Martin Bohus and Tetyana Reinhardt for their long-standing cooperation and invaluable contribution to the development of DBT in Ukraine.

67 Members

The Ukrainian Association of Dialectical Behavioral Therapy (UADBT) was founded in 2019 and now has 67 members. The association members include: psychologists, psychiatrists, psychotherapists who have been trained in the DBT method. President — Yuliia Padun, Vice-President — Yuliia Dzhezhelii. We plan to hold our first conference of the Ukrainian Association online this spring as well as to invite representatives of the European Association. We will continue to develop the association and train new therapists.

What are your plans for the future?

The Ukranian association plans to hold a conference, and invite speakers who are members of the European Association. We'd very much like to see further development of DBT in Ukraine: to have Ukrainian-speaking trainers and supervisors, so that DBT can develop faster in Ukraine, especially considering the urgent need for specialists during and after the war.

Who is in charge?

Yuliya Padun
President of UADBT

Yuliia Dzhezhelii
Vice-president of UADBT

COUNTRY INTRODUCTIONS

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Ukraine

How training is organized?

Basic trainings for specialists take place every year. The trainings are conducted by Tetyana Reinhardt from AWP Freiburg Institute (as the main trainer) in Russian or German with simultaneous translation into Ukrainian, Yuliia Padun and Yuliia Dzhezhelii (as co-trainers) in Ukrainian. The training is organized by DBT Center Ukraine, founded by Yuliia Dzhezhelii and Yuliia Padun.

Current challenges

- Currently there are no Ukrainian-speaking trainers and supervisors who could conduct training and supervision in Ukrainian, which hinders the development of DBT in Ukraine.
- There is no insurance, people pay for their therapy all by themselves.
- There is a war going on, so we do not charge membership fees.

Active local therapy programmes

- DBT skills training. Online. 5 groups every half a year. People fund the training by themselves.
- Individual therapy. In-person, online. People fund the therapy by themselves.
- Therapists' team meetings.
- DBT and DBT PTSD trainings for psychologists. Online. Conducted by Tetyana Reinhardt (as main trainer), Yuliia Padun and Yuliia Dzhezhelii (as co-trainers). Psychologists fund the training by themselves.
- Educational trainings for psychologists in DBT-C method (DBT for children), DBT basics, DBT training for parents. Online. Conducted by Francheska Perepletchikova (as main trainer), Yuliia Padun and Yuliia Dzhezhelii (as co-trainers). Psychologists do not pay for the training. Francheska Perepletchikova offers Ukrainian participants the opportunity to attend free of charge.

RESEARCH DIGEST

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The lived experience of French parents concerning the diagnosis of their children with borderline personality disorder

Léa Villet, Abtine Madjlessi, Anne Revah-Levy, Mario Speranza, Nadia Younes, and Jordan Sibéoni. Borderline personality disorder and emotion dysregulation. 2024 Jul 11(1): 13. Doi: 10.1186/s40479-024-00258-z

This study

This qualitative study, conducted in France through the Family Connections association in Versailles, investigated the experiences of 21 parents whose children were diagnosed with borderline personality disorder (BPD) at the age starting from 14 - 25 years old. Participants were recruited from those who had completed the Family Connections program, a psychoeducational intervention for families of individuals with BPD. Semi-structured interviews were conducted using the IPSE method (inductive process to analyze the structure of lived experience) to explore the lived experiences of these parents. According to the authors, no previous qualitative study had pecifically focused on this population in the context of BPD diagnosis. The study aimed to understand the challenges parents face in receiving the diagnosis, their reactions to it, and the support necessary for them.

Key findings

- Parents reported significant delays and challenges in obtaining a BPD diagnosis for their children, during which several other diagnoses were obtained, like depression, bipolar disorder, eating disorders, and substance abuse disorder. Often received information was conflicting or insufficient. Parents state that psychiatrists: *"spoke vaguely about a borderline disorder, then they went back to bipolarity"* and *"over four years, I can't remember a single time a diagnosis was even considered as a hypothesis"*.
- Parents described a range of experiences when receiving the diagnosis, often informal and lacking in detail. Many felt relief at finally having a name for their child's condition: *"I was grateful to this professional for telling me… this person saved us in a way by giving words to a disorder, because finally someone told me what my daughter had"*, though they also experienced anxiety about the implications: *"There are not many therapists, and there is no medication… Borderline is not the easiest path"*.
- Post-diagnosis, parents often faced inadequate support and continued communication challenges with healthcare services. They also reported concerns about stigma, both socially and within the healthcare system which oftentimes refused care for the diagnosis.

The study underscores the need for clear, early, and detailed communication when diagnosing BPD in children. The findings suggest that healthcare providers should involve parents early in the diagnostic process, informing them about hypotheses and different diagnostic routes. It is necessary to provide comprehensive support throughout their child's treatment, taking time to explain the disorder, concerns and taking time to guide parents through it. Healthcare providers should prioritize transparent communication and early parental involvement in the diagnostic process of BPD.

RESEARCH DIGEST

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The Effectiveness of Dialectical Behavior Therapy Compared to Schema Therapy for Borderline Personality Disorder: A Randomized Clinical Trial


Standard Research Article

The Effectiveness of Dialectical Behavior Therapy Compared to Schema Therapy for Borderline Personality Disorder: A Randomized Clinical Trial

Nele Assmann, Anja Schaich, Arnoud Arntz, Till Wagner, Philipp Herzog, Daniel Alvarez-Fischer, Valerija Sipos, Kamila Jauch-Chara, Jan Philipp Klein, Michael Hüppe, Ulrich Schweiger, Eva Fassbinder
Psychother Psychosom. 2024 Aug; 93(4): 249–263. doi: 10.1159/000538404

This study

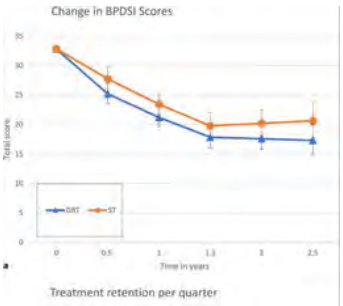
This randomised clinical trial conducted at a specialised treatment centre associated with the University of Lübeck in Germany compared the treatment outcomes of 164 individuals with borderline personality disorder (BPD) in two treatment groups.
One group received DBT and the other schema therapy (ST). Both groups were given 60 min. of individual and 120 min. of group therapy each week over a period of 18 months. According to the authors, no randomised trial comparing these modes of treatment in a sample of this size or larger had been conducted up to date. Participants in the study were severely ill with a mean of 32.80 for BPDSI score, a mean number of 7.26 BPD criteria (SCID-II), 3.99 comorbid SCID-I diagnoses and a mean of 1.35 comorbid SCID-II diagnoses. Most frequent comorbidities included anxiety disorders, depression, avoidant, obsessive-compulsive, histrionic and narcissistic personality disorders.
Planning the study the authors hypothesised that ST might prove superior to DBT in terms of improving the quality of life and reducing general symptom severity and depressive symptomatology while DBT might have larger positive effects on suicidality, self-harm, and dissociation.

Key findings

- There was a significant reduction of BPD severity at 1 year follow-up expressed by the BPDSI-IV total score with large effect sizes in both the DBT and the ST subgroups.
- The within-group pre-follow-up effect sizes were large for the BPD Checklist, Quick Inventory of Depressive Symptoms, Work and Social Adjustment Scale and WHODAS and small to large for the Dissociative symptoms scale and the WHO Quality of life subscales.
- Drop- out rates were similarly low in both treatment arms.
- No significant differences regarding treatment effects comparing DBT and ST were found, however an additional non-inferiority trial would be needed to prove that ST is as effective as DBT.

Implications for DBT practitioners

- DBT and ST are both suitable and effective for even severely affected individuals in terms of BPD.



Note: Although study demonstrates a differential effect size of 0.68 in favour of DBT, certain aspects of author's choice in statistical methodology may have influenced significance of the findings.
Effect sizes:
DBT: d = 2.45
ST: d = 1.78
Differential effect size: 0.68
See pictures on the left for comparison.

RESEARCH DIGEST

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Gender- and Sexuality- Minoritised Adolescents in DBT: A Reflexive Thematic Analysis of Minority-Specific Treatment Targets and Experience.


The Cognitive Behaviour Therapist (2023), vol. 16, e36, page 1 of 27

(BABCP)

ORIGINAL RESEARCH

Gender- and sexuality-minoritised adolescents in DBT: a reflexive thematic analysis of minority-specific treatment targets and experience

J. Camp[1,2], A. Morris[2], H. Wilde[2], P. Smith[2] and K. A. Rimes[1]

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Corresponding author: J. Camp, Email: [redacted]

(Received 5 May 2023; revised 11 October 2023; accepted 12 November 2023)

Abstract

Gender- and sexuality-minoritised (GSM) adolescents are at increased risk of self-harm and suicidal behaviours compared with their cisgender and heterosexual peers. This increased risk is thought to be explained in part by exposure to stigma and societal oppression. Dialectical behaviour therapy (DBT) is an evidence-based intervention for self-harm and suicidal behaviour that may have advantages for supporting GSM young people in distress. No study has yet sought to understand what GSM-associated difficulties may be important to consider in DBT for adolescents, or the experiences of GSM young people in a standard DBT programme. Therefore this study aimed to understand the experiences of GSM young people in DBT and what difficulties and dilemmas associated with their gender and sexuality diversity were thought by them to be important to target in DBT. Qualitative interviews were conducted with 14 GSM young people in a comprehensive DBT programme and were analysed using reflexive thematic analysis. The analysis was supported by two further GSM young people who had finished DBT. The findings were split into three over-arching themes (Identity, Impact of Others, and Space for Sexual and Gender Identity in DBT), each with themes within. The identity-based theme included 'identity confusion and acceptance'; the relationship-based theme included 'cis-Heterosexism' and 'community connectedness'; and the space within DBT themes included 'negotiating focus and targeting in DBT' and 'creating safety in DBT'. Findings are discussed in relation to implications and recommendations for therapists working with GSM young people within and outside of DBT.

Key learning aims

(1) To learn about what gender- and sexuality-minoritised (GSM) young people consider to be important GSM-associated contributors to distress and thus potential treatment targets in DBT.
(2) To learn about what GSM young people felt were barriers to negotiating GSM-associated difficulties as a focus in DBT and how safety was created in the therapeutic relationship.
(3) To consider potential implications and recommendations for improvements to practice when supporting GSM young people in therapy.

Keywords: Adolescent; Dialectical behaviour therapy; LGBTQ+; Non-binary; Self-harm; Sexual minority; Trans

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Jake Camp, Andre Morris, Helen Wilde, Patrick Smith, K A Rimes.
*T*he Cognitive Behaviour Therapist. 2023;16:e36. doi:10.1017/S1754470X23000326

This study:
This qualitative study explores the experiences of gender- and sexuality- minoritised (GSM) adolescents in a standard Dialectical Behaviour Therapy (DBT) program. The study included 14 participants and aimed to identify specific GSM-related treatment needs and challenges these adolescents face during DBT. Through Reflexive Thematic Analysis, the researchers uncovered three key themes: Identity, Impact of Others, and the importance of creating space for gender and sexual identity within therapy. The findings are organised according to the key themes and include recommendations for DBT skills and strategies that address difficulties in these areas, as proposed by the study participants. Taken together, this highlights the need for GSM-specific support in DBT, with participants suggesting ways to adapt therapeutic practices to better meet the needs of GSM adolescents.

Key findings:

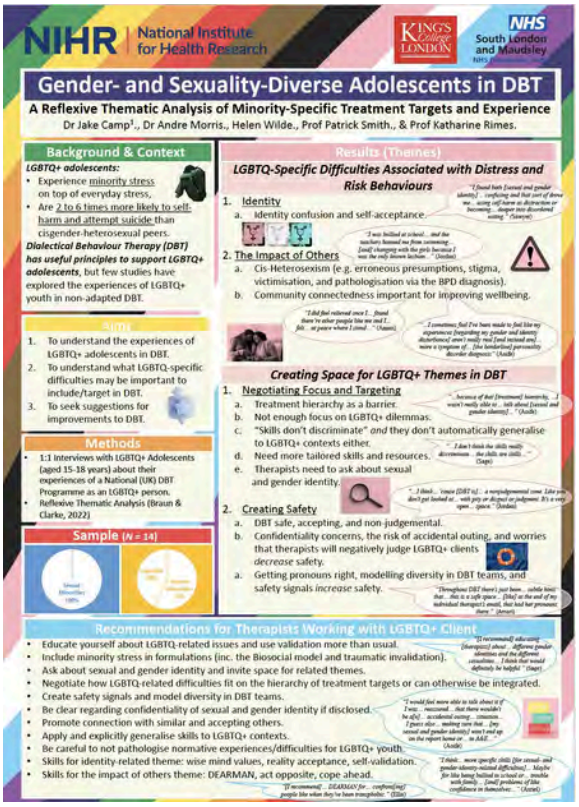
- **Identity.** Many participants reported significant distress and confusion surrounding their sexual and gender identities, especially regarding gender identity. This confusion contributed to mental health struggles such as self-harm and eating disorders. Internalised stigma, including homophobia and gender-related invalidation, further complicated their acceptance of their identities. Participants suggested that DBT should better address these issues to enhance self-awareness, self-acceptance, and self-expression, which are critical to improving their mental health. DBT treatment strategies for identity and self-acceptance can be accessed here (link).
- **Impact of Others.** Participants experienced a range of cis-heterosexism, from microaggressions to overt discrimination, often affecting their mental health. Misgendering, assumptions about sexuality, and stigmatisation (e.g., stereotypes about bisexuality) were common experiences. These contributed to feelings of invalidation and social isolation. Conversely, when participants encountered acceptance and understanding, especially within their DBT groups, it positively impacted their well-being. Many highlighted the need for therapists to be more proactive in addressing and validating GSM-related struggles in the face of societal prejudice. Several participants emphasised the importance of connecting with other GSM individuals for support and validation. Being part of a community helped normalise their experiences and offered relief from societal rejection. Peer support within the DBT skills group was noted as beneficial, and some participants expressed a desire to see more GSM representation among DBT therapists. DBT treatment strategies can be accessed here (link).
- **The importance of creating space for gender and sexual identity within therapy.** Many participants found that the DBT treatment hierarchy, which prioritises life-threatening behaviours, left little room to discuss their sexual and gender identities, even though these were key contributors to their distress. While DBT skills were generally helpful, they felt there was insufficient focus on identity-related struggles. Participants recommended explicitly integrating GSM-related content into the therapy and ensuring therapists are trained to address these issues effectively. Overall, participants felt that DBT provided a safe space to explore their identities compared to other therapeutic settings. However, they also emphasised the importance of ensuring that this safety is maintained through respectful practices, such as consistently using correct pronouns and addressing concerns about confidentiality. Some participants worried about being outed or misjudged, suggesting that therapists clarify confidentiality boundaries and routinely check in on the evolving identities of GSM youth.

(... see the next page)

The study also presents a series of comprehensive recommendations for clinical practice when working with adolescent patients diagnosed with GSM. They are informed by study participants and previous research in this topics (Camp, 2023; Cohen et al., 2021; Skerven et al., 2019; Sloan et al., 2017; Tilley et al., 2022). The article makes the following recommendations, which are presented here in direct quotation:

"General considerations:

- *Consider the potential for pathologising normative behaviours, particularly with the BPD diagnosis;*
- *Increase the use of validation strategies and the acceptance end of the dialectic;*
- *Accept that sexual and gender identity may change over time;*
- *Engage with work on your own identity, biases, and blind spots;*
- *Educate yourself on GSM-related issues;*
- *Do not over-rely on GSM people to educate you;*
- *Include minority stress and GSM identities in the biosocial model and formulation of difficulties;*
- *Consider the role and impact of traumatic invalidation;*
- *Consider safety with the client when inviting change in cis-heterosexist environments.*



Creating safety in DBT:

- *Be overtly accepting, supportive, open, and non-judgemental regarding GSM identities;*
- *Model and self-disclose diversity;*
- *Make parameters of confidentiality regarding sexual/gender identity clear;*
- *Ensure clients access therapy from a safe location where they cannot be overheard;*
- *Be clear about where related information will be recorded/disseminated, and who has access;*
- *Involve parents/carers in interventions to increase support/validation (in consultation with the client);*
- *Create safety signals in the environment (e.g. pronouns in emails, pride symbols, etc.);*
- *Promote social connection with similar and accepting others;*
- *Make effort to get pronouns and names correct, and be non-defensive if mistakes are made (refer to the fallibility and consistency agreement; Linehan, 1993).*

Negotiating targets and focus in DBT

- *Ask about sexual and gender identity and name and pronouns (conveying it is optional);*
- *Invite optional space for sexual- and gender-identity-related difficulties/dilemmas;*
- *Collaboratively negotiate how to make space if this does not fit with traditional targeting;*
- *Consider how sexual- and gender-identity- and minority-stress-related cues, experiences, and context may fit in the hierarchy of treatment targets, diary-card monitoring, formulations (including the transactional biosocial model), and chain analyses;*
- *Apply and generalise skills to relevant dilemmas explicitly;*
- *Include relevant psychoeducation and complementary skills for GSM-associated targets (these may be from sources outside of DBT, where these do not exist within the DBT model).*" (Camp et al., 2024).

RESEARCH DIGEST

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The Wise Mind Balances the Abstract and the Concrete

Igor Grossmann, Johanna Peetz, Anna Dorfman, Amanda Rotella, Roger Buehler
Open Mind (Camb) 2024; 8: 826–858. 28. doi: 10.1162/opmi_a_00149

This study:
In their series of studies presented in this article Igor Grossmann (University of Waterloo) and colleagues seek to deepen the scientific conceptualization of wisdom. The design of the studies is based on the so-called Common wisdom model. Various findings of social and behavioral sciences have identified mental traits they estimated to be at the heart of wise decisions and perspectives: 1) intellectual humility (i.e., recognition of limits of one's knowledge), 2) open-mindedness to multiple ways an issue might unfold and change, 3) multi- perspectivity on the issue at hand, and 4) a search for compromise in resolving opposing viewpoints. These features have also been linked to intra- and interindividual wellbeing, as well as prosocial attitudes. The authors aimed to elicit how a person's representations of social events in their mind are linked to these attributes of wisdom. The two key questions they try to answer in the article are about the role of abstract and concrete thinking and their role in forming a wise mind: 1) Are abstract and concrete mental representations opposing positions on a single spectrum or do they rather stem from two different categories? 2) How do abstract and concrete mental representations feed into a higher quality of wisdom? The participants of the study (from the US and UK) were asked to reflect on personal and standardized social interactions.

Key findings
- Abstractness and concreteness were found to be two different complementary features of mental representations rather than opposing poles of a single continuum.
- Wise reasoning is an achievement fed by both abstract and concrete construals.
- Individuals associated with high wisdom can be characterized by greater use of both abstract and concrete themes compared to the low wisdom group.
- Participants demonstrating a greater balance and switching between these construal types exhibited higher wisdom. A possible mechanism might be that flexible switching leads to multi-perspectivity of a given situation.

Possible clinical implications
- The findings complement the concept of wise mind used in DBT, drawing attention to another aspect involved in a broadening view on a situation: The interplay of very unique, momentary and specific emotional responses and facts (concrete construals) and general principles and tools (values and skills) the individual has access to.
- Being mindful of these apparently equally valuable levels of perception might help both therapist and client to understand and solve at least some of the dialectical dilemmas at hand.

"Imagine you are planning your first trip to Paris. As you close your eyes, generic images you have seen in countless movies come to mind: the Eiffel Tower, croissants, or perhaps the Louvre Museum. After you open your eyes, you start contemplating specific steps to realize your dream: examining prices when booking your flight, checking the weather to prepare clothes to pack, and studying the city map when reserving the hotel room. The former concerns the answer to the question "why" you may want to go to Paris—i.e., its general desirability. The latter concerns the "how" such a trip may be realized—i.e., the specifics enabling you to get there. These are different ways of thinking about the same thing: one is more abstract, while the other is more concrete. Which way results in a wiser judgment? We posited that this may be the wrong question. Consistent with recent theorizing in cognitive and social sciences, we proposed that wiser reflections benefit from a combination of both abstract and concrete mental representations." (Grossmann et al., 2024)

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Sheri van Dijk on the skill of self-validation

To make the concept of self-validating a little easier for clients, I break it down into three levels:

1. Acknowledging: The most basic level of self-validation is simply acknowledging the presence of the emotion rather than judging it; for example, telling yourself, I feel unhappy. Just acknowledging or naming the emotion and putting a period on the end of the sentence rather than going down the road of judging it validates the emotion.
2. Allowing: The second level of self-validation is allowing, which is essentially giving yourself permission to feel the feeling; for example, telling yourself, It's okay that I feel unhappy. This takes not judging the feeling one step further, affirming that it's okay to feel this way. This doesn't mean liking the feeling or wanting it to hang around; it just means acknowledging that you're allowed to feel the emotion.
3. Understanding: The highest (and hardest) level of self-validation is understanding. This level, which goes beyond not judging the emotion and saying it's okay to feel it, involves having an understanding of it; for example, It makes sense that I feel unhappy, given the difficulties I have managing my emotions and the chaos this causes in my relationships and my life.

Most clients with emotion dysregulation have a lifelong pattern of invalidating themselves, so, again, it makes sense that this is typically a very challenging skill for them. It's likely that they'll start out self-validating most emotions at the first level—acknowledging the emotion—and that even this will be difficult for many of them. But over time, they'll be able to move on to the next level, and then the next. It's also natural for people to move at a different pace with different level, and then the next. It's also natural for people to move at a different pace with different emotions. Some emotions will be easier to validate than others.

It's often helpful to have clients write a list of validating statements that they can read when they notice that they're invalidating themselves. Recently, I was working with a client who has BPD and regularly thinks I'm going to abandon her. When these fears of abandonment come up, she regularly invalidates herself with self-talk like, It's ridiculous; I should be able to manage this better by now or I'm a grown woman. I shouldn't still be feeling this way. Why can't I get over this?
I helped her start a list of self- validating statements to use when these feelings arose. Here are some examples of what we came up with:

- I'm feeling anxious about Sheri leaving me. (level 1)
- It's okay that I'm feeling this way. (level 2)
- I'm worrying that Sheri will leave me. It's uncomfortable, but it is what it is. (level 2)
- It makes sense that I get anxious about Sheri leaving me because of the relationships I've lost throughout my life. (level 3)
- It makes sense that I get anxious about people leaving me because of the abuse and neglect I experienced as a child. (level 3)

Start working on a list of self-validating statements with clients in session and then have them continue working on it for homework. At the next session, review the list to see what they've been able to add, if anything. Many clients find this difficult to do on their own, but hopefully they're able to come up with one or two additional statements. Have clients carry this list with them so they can read the statements whenever they notice that they're invalidating their emotions. In this way, over time they'll be able to change the way they speak to themselves about how they're feeling, rather than just falling back into old, familiar patterns of negative self-talk and judgments.

More on this..

DBT Made Simple:
A Step-by-Step Guide to Dialectical Behavior Therapy

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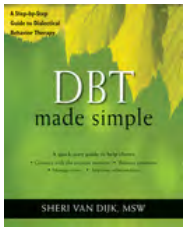

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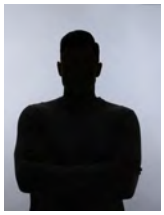

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