

Dialectical Behavior Therapy and Skill Training: Areas of Use and Importance in Preventive Mental Health

Diyalektik Davranış Terapisi ve Beceri Eğitimi: Kullanım Alanları ve Koruyucu Ruh Sağlığındaki Önemi

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Öz

Diyalektik Davranış Terapisi® üçüncü dalga terapilerin içinde yer alan ve kanıta dayalı önemli yaklaşımlardan biridir. Diyalektik felsefe odağında kabul kavramı üzerinde duran bu yaklaşım, bireysel terapinin yanı sıra temel beceri eğitimleri yoluyla danışanın kabul ve değişim sürecine yardımcı olmayı amaçlar. Beceri eğitimleri mindfulness (bilinçli farkındalık), kişilerarası etkililik, duygu düzenleme ve sıkıntıya toleransı artırma olmak üzere dört modülden oluşur. Bu yazının temel amacı diyalektik davranış terapisini tanıtmak ve bu kanıta dayalı terapi modelinin öne çıkan araştırma bulgularını özetlerken bu yaklaşımın sunduğu beceri eğitiminin etkin bir müdahale yöntemi olarak kullanımının yanı sıra koruyucu ruh sağlığındaki kullanımına da dikkat çekmektir.

Anahtar sözcükler: Diyalektik davranış terapisi, beceri eğitimi, koruyucu ruh sağlığı.

Abstract

Dialectical Behavioral Therapy®, is one of the evidence based therapies and known as one of the third way behavior therapies. It is based on dialectical philosophy and within this notion treatment involves both change and acceptance. Therapy offers skills training as well as individual therapy. Dialectical behavioral therapy skill training involves four different modules: mindfulness, distress tolerance, emotion regulation and interpersonal effectiveness. One of the aims of this review is while providing general information regarding dialectical behavioral therapy and its skills set, review the research on modified application of the therapy and its skills training. This review also draws attention to the recent interest in using dialectical behavioral therapy skills training in preventive mental health.

Keywords: Dialectical behavior therapy, skill training, preventive mental health.

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DIALECTICAL BEHAVIORAL THERAPY® (DBT), is one of the important evidence based therapy approaches and known as one of the third wave behavior therapies. Principle focus of this approach is constructed over acceptance notion based on dialectical philosophy. Treatment method puts emphasis on four fundamental problems: Self-confusion, impulsivity, emotional dysregulation and interpersonal chaos (Linehan 1993). For these fundamental problem areas, basic skills training are also administered to the client/patient as a part of the treatment along with individual therapy. Skills training composed of four modules; Mindfulness, Distress Tolerance, Emotion Regulation and Interpersonal Effectiveness. DBT has been developed for Borderline Personality Disorder (BPD) and is a therapy approach based on evidence over the control of impulsivity and emotion dysregulation (Chaphan 2006). Used in many clinical and risky groups and it is observed that self-harm as well as suicidality behaviors are decreased dramatically in risky groups. Lately, DBT has been brought into play to increase the well being and skills training strengthening (Pistorello et al. 2012, Engle et al. 2013, Panepinto et al. 2015). While this therapy approach provides a well-established intervention model, recently it is emerging as a prevention model. DBT's scope of application is limited in Turkey and new researchers are started giving attention to this subject. The main aim of this paper is to inform researchers and clinicians about DBT and its skills training use both as intervention and prevention model at various settings.

Dialectical Behavior Therapy

DBT was initially developed around emotion dysregulation as a treatment for suicidal patients who met the criteria of Borderline Personality Disorder (BPD). In the beginning therapy has been constructed for the treatment of behaviors such as suicide attempts, nonsuicidal self-injury and suicidal ideations. With the studies realized recently, treatment has been implemented to different clinical groups based on evidence; such as adults with depression, recurrent treatment resistant depression patients or disorders of overcontrol, women with eating disorder, adolescents and college students having BPD tendencies, these groups have been studied with DBT (Linehan 2015a).

Fundamentally, DBT is an evidence based treatment and the efficiency of the therapy model has been supported with many randomized controlled trials (Linehan et al. 1999, Turner 2000, Pistorello et al. 2012). Research findings indicate an important decrease on suicide attempts and self injury behaviors; it is also evident that emotional and behavioral problems such as depression, hopelessness, anger, substance dependence and impulsiveness are also decreased with DBT. (Linehan et al. 1991, 1999, Turner 2000, Koons et al. 2001, Courbasson et al. 2012, Harned et al. 2014, Andreasson et al. 2016). Right along with this type of symptoms and behavioral problems DBT is also increasing endurance, adjustment abilities and self confidence of patients having BPD (Lieb et al. 2004). In studies carried out with low risk groups, there are evidence regarding improvements in daily life functioning and wellbeing (Linehan et al. 1991, Woodberry and Popenoe 2008, Fleming et al. 2015).

Linehan introduces biosocial approach as the basic theoretical framework and explains psychological disorders, especially BPD over deficiencies with regards to emotional dysregulation. Biosocial model involves both biological and environmental factors in emotion regulation. According to this model biological factors, predisposition to more

intense and frequent emotions and predisposition to impulsivity were main focuses. On the other hand environment can be invalidating to personal needs by rejecting communication or dismissing the intense emotions of the person and by doing this not providing opportunities to learn skills to regulate intense emotions. (Linehan 2015a). Fundamentally, DBT is a cognitive behavioral based therapy which is founded on behavioral science, dialectical philosophy and Zen/contemplative practice (Linehan 1993, 2015a). It is constructed over gaining effective behaviors by the person, by systematically using learning principles of behavioral sciences as a base. DBT covers abilities such as problem solving, behavior analysis, insight and solution analysis (skills training, exposure, cognitive restructuring and risk management) (Linehan 2015a). One of the main foundations of DBT is based on dialectics which covers both change and acceptance. Dialectics is a kind of world view explaining reality as “Every person and everything is connected in some way”, “Everything is made of opposing forces/opposing sides”, “Change is the only constant”, “Change is transactional” (Linehan 2015). Lastly, DBT is based on Zen oriented alternative applications. Conscious awareness applications from Zen practices have been integrated into DBT with a complementary approach. Therefore, it would not be wrong mentioning a east-west synthesis here. It is possible to see the systematic perspective of behavioristic approach in company with acceptance and submission while targeting the strengthening of both the relationships and autonomy of the person. Wise-mind concept frequently mentioned in DBT is actually a mechanism embedded into the therapy (Linehan 1993).

DBT emphasizes that skills required to be learnt for a life worth living (Linehan 1993, 2015a, 2015b). Generally, DBT targets developing suitable skills by defining the problem. The fundamental aim of therapy is teaching individuals how to overcome invalidating environments and excessive rejection sensitivities. Client/patient learns skills from acceptance and change skill sets in accordance with dialectics. Within the therapy process, therapist’s function is to provide a validating environment. Consultation team and suicide risk assessment and management are important elements for the process of therapy, especially for risky clinical groups (Linehan 1993).

Therapy Process

DBT addresses the targets to be examined in therapy in four different stages (Linehan 2015a). At first stage therapist targets eliminating behaviors that might be life-threatening, behaviors that might not be controlled and might interfere the therapy process – for example, not being able to attend to sessions and behaviors that might affect the quality of life of the patient (for example, substance dependence) – and at this stage it is important to have the skill sets thought in DBT modules. Stage two is referred to quiet desperation. In this stage, patients can control their behaviors, whereas they feel suffering due to their traumatic history. Decreasing behaviors related to trauma, increasing emotional modulation, self validation, realistic decision making and judgment, increasing emotional experiencing and active problem solving are aims of the treatment in stage 2. In the third stage problems causing the general unhappiness of the individual are aimed. According to DSM-5 (Diagnostic and Statistical Manual of Mental Disorders) problems at this stage are behaviors and symptoms classified as behavior disorders (American Psychiatric Association 2013). Stage 4 is about incomple-

teness (lonely, empty) and targeting the behaviors that are hindering the joy and freedom.

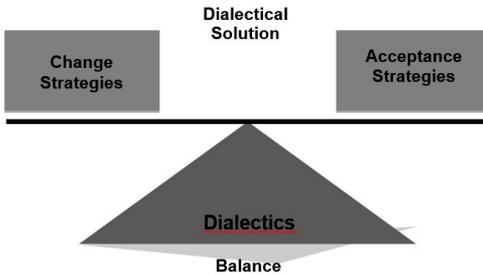


Figure 1: Dialectical Solution

Linehan Institute/ Behavioral Tech, LLC, 2015 Intensive Training Manual

DBT Skills Training: Acceptance and Change Skills

Dialectical philosophy forms the foundation of DBT. Therefore dialectical strategies are used in the therapy to balance between acceptance and change. The acquisition of such skills is the main of the individual therapy and the skills training. In addition, DBT especially highlights the importance of validation. Validation in DBT involves focusing on the current context of a client's problems, acknowledging that personal thoughts, emotions, behaviors are acceptable in the client's context, and communicating that understanding to client (Linehan 1993). This concept shows similarities with empathy, unconditional love and acceptance notions (Özeke-Kocabaş and Üstündağ-Budak 2017). Validation undertakes the task of balancing acceptance and change skills (Figure 1).

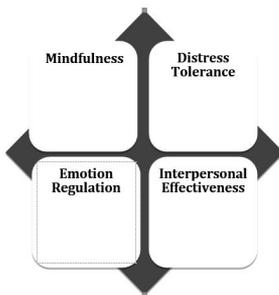


Figure 2: DBT skills training modules

DBT skills training consists of four modules: Mindfulness, Distress Tolerance, Emotion Regulation and Interpersonal Effectiveness (Figure 2). While Mindfulness and Distress Tolerance Skills are targeting acceptance based skills; Emotion Regulation and Interpersonal Effectiveness are consist of change based skills. Throughout the comprehensive DBT application process these four modules are being completed as semiannual two cycles (Figure 3). Leader's role in the group includes running group meetings, preparing the content of the session, conducting initial behavioral analysis

and presenting new materials about skills. Leader also monitors participants' contribution to group and their attendance. Co-leader holds a mediatory position in possible tension that might occur between participants and sets a good example regarding behaviors that provide a new and alternative point of view. Co-leader supports the leader in understanding the needs of the group; for example, follows up the needs of the clients in doing their homework (Linehan 1993, 2015a).

Each module is created to intervene problems in different areas. Mindfulness teaches focusing to the present moment without judgement. Goal of the mindfulness module is to reduce suffering, increase happiness and experience reality as it is. Acquisition of mindfulness skills are matter to DBT and skills training. DBT mindfulness skills cover the reflection of Eastern spiritual training into therapy as meditative behaviors. As a set of skills, mindfulness practice is intentional process of observing, describing and participating in reality non-judgmentally, in the moment and with effectiveness (Linehan 2015a, 2015b). In mindfulness module, three different sets of mind are being mentioned as; rational mind, emotion mind and wise mind. Rational mind is kind of thinking logically and rationally; taking the reality as empirical facts; does not include emotions. Emotion mind is to have hot cognitions, facts are distorted with emotion, logical thinking is not possible. Wise mind is the synthesis of emotion mind and reasonable mind. Intuitive knowledge is also come into existence with this synthesis. DBT teaches mindfulness skills over "what and how skills". "What skills" are being thought under three main titles as observe, describe and participate. Observe covers skills such as being aware of life, control of mindfulness, observation of the movements of feelings and thoughts and invitation to an open mind. Describe covers "putting words on the experience" and to "put experiences into words"; participate skills covers becoming one with the experienced thing and acting together with the wise mind. "How skills" are related with how "what skills" are realized: Without judgement, with one-mindfully and in an effective way.

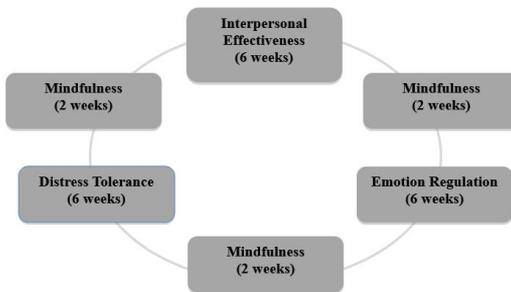


Figure 3: DBT Skills Training Modules 6 month treatment cycle .

Linehan Institute/ Behavioral Tech, LLC, 2015 Intensive Training Manual

Interpersonal effectiveness primarily focuses on achieving a goal while protecting relationships and self respect. These skills are similar to assertiveness training content. At the same time skills given in this module covers putting an end to destructive relationships hurting the individual. Reaching a common ground in relationships, as well as a balanced acceptance with change in relationships forms the general framework of the

module. Lots of skills are being thought in this module; for example the skills expressed with DEAR MAN acronym; Describe, Express, Assert, Reinforce, stay Mindful, Appear confident, Negotiate.

Emotion Regulation covers skills teaching the management of especially hard and painful emotions. What is intended in this module is not getting rid of emotions; on the contrary, being able to define emotions and their expression are being studied. This module includes the observation of emotions, its description and the understanding of emotion's intent; reducing emotional vulnerability by decreasing oversensitivity and increasing positive feelings; and skills over decreasing emotional suffering.

Distress Tolerance aims crisis management and skills regarding accepting the reality as it is (teaches skills such as Distraction, Self Soothe, Relaxing) (Linehan 2015a, 2015b).

Comprehensive and Adapted DBT Programs

DBT Program also known as Standard DBT or Comprehensive DBT is a program whose success has been established with high risk patients for BPD as mentioned above (Linehan 2015a) and developed basically for patients having severe emotion dysregulation. Standard DBT program composed of treatment modes involve individual therapy, skills training, between session coaching-phone consultation and therapist consultation. Annual therapy contract with the patient is signed and skills training is served as cycles of 6 months. Target is to enhance the development and motivation of the client in individual therapy. Dialectical strategies are used to establish an acceptance and change balance. In addition, therapy interfering behaviors and life threatening behaviors are going to be handled primarily in therapy sessions. In skills training, target is to modify skill deficits and maladaptive coping behaviors. Skills generalization, skills strengthening and acquiring skills are basic behavioral targets. Skills training is usually set up as a group of 4 to 10 individuals and run by two DBT therapist, one of whom is a leader, the other one is a co-leader. Assignments and diary cards are being evaluated in group sessions, acquisition of new skills are being reinforced (Linehan 1993).

On the other hand, standard DBT program might be adjusted in accordance with the sources and requirements of the group for different groups and different needs of these groups. For example, it is possible to put constraints on the period of modules or it is also possible to concentrate on particular skills. Suggested adapted program examples are being supplied by Linehan (2015a). For example, standard 24 Weeks skills training is provided for patients having BPD or PTSD, this training might be repeated twice a year, and in another schedule training is provided to teens having high emotion dysregulation and high suicide risks with their families in 25 Weeks. DBT skills training set has been applied in both hospitals and in clinical environments and successful results have been obtained; for example, positive changes have been observed in behaviors of individuals having BPD, having suicidal ideation and non-suicidal self-injury (Andreasson et al. 2016).

Stanley et al. (2007) have designed a study to examine the effectiveness of a short term DBT implementation over patients having suicidal tendencies and non-suicidal self injury (NSSI), which is a DBT application to individuals diagnosed with BPD. 20 patients having BPD, which also taking psychotropic drugs and having actual suicidal

tendencies were included into this study. Urge to self injure, self injury episodes, suicide ideation and subjective distress were evaluated over diary cards after six months following DBT application. According to the results of the analysis, decrease has been found in hopelessness, depression, subjective distress, suicide ideation and NSSI urges.

Other studies carried out especially with youngsters outside of standard clinical applications of DBT are showing effective results. For instance, Woodberry and Popehoe (2008) adapted standard DBT protocol in a public health hospital. Also Miller et al. (1997) adapted a shortened version of Standard DBT program to adolescents. Assessments and feedbacks form families showed significant changes in adolescent's internalizing and externalizing behaviors. In parallel with these changes less depressive symptoms reported by parents. These studies are showing the effectiveness of Standard DBT applications in different groups.

Adapted DBT Programs with College Students

College students become prominent in studies intended for the implementation of adapted DBT skills training to different groups. Some of these studies cover the adapted form of standard DBT program with college students who met the criteria of BPD. For example, in a study realized by Engle et al. (2013), DBT model was applied to college students to overcome maladaptive coping strategies and other mental health problems. Sarah Lawrence College (SLC) Health Services provided the Standard DBT involving four modes of treatment. In this college setting, the DBT comprehensive was provided to young adults with BPD; however, the skills training groups in SLC were implemented shorter than the comprehensive DBT. Their program according to the comprehensive DBT in college setting presented decrease in psychiatric hospitalizations and decrease in hospitalizations due to substance use. According to results, higher impact of DBT for students who met criteria of BPD was found to be significant. In the study, it showed that adapting DBT into college setting improved students' coping strategies and their daily functioning.

In another study carried out in a college setting regarding the effectiveness of DBT (Pistorello et al. 2012), standard DBT has been applied to 63 subjects in between the ages of 18 to 25 having high level of stress, and having suicidality and depression as well as BPD. Standard DDT has been adapted by considering the needs of this risky group. DBT significantly had better outcomes on depression, NSSI, suicidality and social adjustment. More patients kept away from NSSI at post-treatment than treatment as usual (62 % vs. 31 %). The results showed that DBT could be modified in order to treat students with complex, multi-problems and suicidal profile in college counseling centers.

In another study, Panepinto et al. (2015) investigated the efficacy of a modified standard DBT program with general college population. In their research, 64 college students between ages of 18 and 45 were examined for 14 DBT groups. Students were recruited due to their deficits in behavioral skills, suicidal ideation, NSSI, substance use/abuse, eating disordered behaviors, unsafe sexual practices, impulsive behaviors and general lack of coping strategies. Sessions continued 6 up to 13 weeks with groups. DBT treatment consisted of 90 minute skills training in a week, individual sessions and skills coaching. All modules of skills training applied to groups. In the DBT program, targeted behaviors (such as; confusion about self, impulsivity, emotional dysregulation,

and interpersonal chaos) decreased significantly. Reduction observed in depression and overall distress. Furthermore, significant increase in improvement of interpersonal sensitivity, and decrease in obsessive compulsive, psychotic, somatic, paranoid ideation, and phobic anxiety symptoms observed.

On the other hand, in programs modified outside the scope of DBT protocol, DBT skills training as a stand alone treatment is also being implemented. Despite the fact that standard therapy is very efficient for the patients, some obstacles about resources lead to implement DBT skills training alone with college students. For instance, Meaney - Tavares and Hasking (2013), implemented short DBT skills training program throughout eight weeks. Over 17 students who met criteria of BPD was found to show less depression, hospitalization, self-blame and show higher coping mechanisms in order to solve their problems.

DBT Skills Training as a stand-alone treatment was also conducted among undergraduate students with significant emotion dysregulation by applying a shortened version (Rizvi & Steffel 2014). It was also measured additive benefits of mindfulness in group skills training while comparing emotion regulation skills only with both emotion regulation skills and core mindfulness skills together. Besides, the effectiveness of 8 weeks skills training over emotion regulation, mood, and social and academic functioning were evaluated. 24 undergraduate students between ages of 18 and 29 at a major public university who had problems with emotion regulation participated to study. Each group consisted of 8 weeks skill program, 2 hours per week, which adapted from Linehan's DBT Skills Training Manual for borderline personality disorder. Group received 2 weeks of mindfulness skills and 6 weeks of emotion regulation skills training. The Emotion Regulation group received only emotion regulation skills throughout 8 weeks. According to the findings, feasibility and efficacy of abbreviated skills training were supported; students benefitted from this program and showed progress on emotion regulation skills. Otherwise, there was no additive support for efficacy of mindfulness skills training. Participants provided positive feedback after treatment/training. In result, short version of DBT skills training may be effective to solve problems about emotion dysregulation, and also it is cost effective for mental health services and for academic performances of universities.

Furthermore, DBT skills training was evaluated to indicate 11 week DBT skills training in addition to individual therapy to increase adaptive behavioral skills and capacity for emotional regulation. In addition, it was aimed to compare it with treatment as usual among college students with cluster B personality disorders or cluster B personality traits (Chugani et al. 2013). It was found that time limited DBT skills training group was effective with college students who met criteria from cluster B personality disorder. In the study, dysfunctional coping, difficulty of emotion regulation decreased and DBT skill use increased compared to treatments as usual.

Another study aimed to examine the efficiency of DBT based skills training implemented on students having emotion regulation by Gülgez and Gündüz (2015); study applied to 18 1st, 2nd and 3rd grade students (9 for treatment group, 9 for control group) from the University of Mersin. After working on mindfulness module in first three weeks, Emotion Regulation Skills covered for the following two weeks, and stress Tolerance Skills studied for two weeks and the focus of the last week was Interpersonal Effectiveness Skills. DBT based skills training was implemented as two hours per week.

It was found that compared to the control group, the emotion regulation scores of the treatment group decreased significantly. According to study, DBT Based Emotion Regulation Program was effective to reduce difficulties of emotion regulation among college students.

In another example of studies conducted with different groups regarding the efficiency of DBT skills training with undergraduate students, 33 undergraduate students between the ages of 18 and 24 with ADHD were recruited (Fleming et al. 2015). DBT program adapted for undergraduate students selected from three different universities has been created according to needs of this group and efficiency of the program has been tested. Intervention involved 15 minute individual pre-group meeting and eight weekly 90 minute group sessions, 10-15 minutes phone consultation, and 90 minute booster group session. In result, DBT group skills training was effective in improving symptoms of ADHD compared to self guided skills training. Results expressed that adolescents showed improvement in executive functioning and their quality of life. It is detected that participants have improvements in conscious awareness and planning due to the results.

The affectivity of modified DBT has been studied also with various adolescence groups apart from college population. Geddes et al. (2013) also examined whether or not the DBT treatment program with adolescents in order to find improvement of their trauma related symptoms, emotion regulation, at the same time to find decrease in suicidality and NSSI. 6 female adolescents from 14 years to 15 years were recruited for the adult DBT program which was modified (DBT-A). In the family skills training, 4 mothers and 2 fathers were included; and 5 participants participated to three month follow up. DBT-A Program was evaluated from adult program transformed into adolescent program which consisted of individual therapy, a multifamily skills training group, phone consultation, and a therapist supervision/consultation group. The family skills group continued over the course of 18 weeks. Five modules were included in the program; Core Mindfulness, Distress Tolerance, Emotion Regulation, Interpersonal Skills, and Middle Path. In the result, it was supported that adolescents in DBT-A program showed reduction in trauma based symptoms, self injurious behaviors and suicidal thoughts. According to assessments, there were decrease in symptoms of anxiety, anger, depression, and posttraumatic stress at the end of the treatments.

A study was prepared for the non-suicidal outpatient young adolescents with Oppositional Defiant Disorder (ODD) in order to assess the efficacy of adjusted DBT Skills Training (Nelson-Gray et al. 2006). 32 adolescents who met ODD diagnosis were assigned to groups as 5 to 9 members for 16 weekly, 2 hours therapy sessions. All modules including core mindfulness, interpersonal effectiveness, emotion regulation and distress tolerance modules, were provided as a modification of original version in order to make materials age appropriate. Parents were informed regarding the content. In this study a follow-up was also carried out and in the results, reductions of ODD symptoms and externalizing symptoms were found to be significant. An increase in interpersonal strength was also reported. Youngsters reported decrease in depression and internalizing symptoms. Qualitative data also showed the effectiveness of treatment. According to family reports, there were positive meaningful changes for their children's behaviors. These studies support the efficacy of adjusted DBT skills training

with various adolescence groups, and provide an insight to studies that might be used on young groups based on prevention.

DBT Skills Training, Preventive Mental Health and Research Findings

DBT and its skills training are becoming prominent as an effective intervention method for high clinical profile or borderline individuals (Fleming et al. 2015). However; both DBT and well-structured skills training set of DBT have very little implementations and researches in the usage of improving the state of well-being and preventative mental health. For example, positive results of DBT with low risk groups are being reported. DBT Skills were taught to at risk high school students to promote wellbeing of academic performance and to acquire coping skills toward difficult life situations (Leichmant et al. 2008). Study involved approximately 1625 high school students who got academic elective course of Wellbeing and semester of Psychology course within a specialized program. Strategy was to support as many students as possible by utilizing limited sources; it was offered options, one of which was “Academic Elective Course (Skills for Wellbeing Class)”, the other one was “Semester of Psychology Course (Within a Specialized Program)”. Their implementations were significantly successful for at risk high school students. They reported that skills were helpful in daily situations according to higher grades of children and higher academic performance at school.

Studies carried out focusing on well-being and improving the quality of life of university students in Turkey by implementing adapted DBT skills training might be given as an example to studies focusing on prevention. Üstündağ-Budak et al. (2016) studied the efficacy of adapted DBT skills training with the target of improving the quality of life and building a meaningful life by university students. In this pilot study DBT skills training modules are being studied based on well-being, it was implemented for eight weeks by applying an experimental design. Training applied to two groups composed of first-second and third-fourth class students; mindfulness, interpersonal effectiveness and emotion regulation modules implemented for a period of eight weeks as two hours sessions and the effects of adapted DBT skills training over this two student groups evaluated over pre and post-tests. Findings are showing a meaningful decrease in depression, anxiety and stress scores following the skills training. This study indicates the benefits of university students from DBT skills for the purposes of increasing psychological well-being. Besides, with similar purposes Üstündağ-Budak and Özeke-Kocabaş (2017) implemented DBT skills training by integrating those skills into courses given in the Semester. Four skills module of DBT skills training set was provided as part of Developmental Psychopathology Course to fourth grade students over a period of 10 weeks, an hour per week. Adapted DBT skills training program supported by assignments and results evaluated by pre and post-tests considering emotion regulation and self-compassion. Results are showing that 10 weeks of adapted DBT skills training program is helpful for students especially in emotion regulation and reducing the stress.

Conclusion

Being a member of third wave therapies, DBT has not been emerged as a widespread therapy approach in Turkey yet. One of the fundamental objectives of this paper is to

introduce DBT and while summarizing prominent research findings of this evidence-based therapy model, usage of the model in preventive mental health along with the usage of skills training provided with this approach as an effective intervention method. As a result of this compilation DBT stands out as both an effective intervention and preventative mental health approach.

However; both DBT and DBT skills training have scarce implementations and researches in improving the state of well-being and its use in preventative mental health. Improvement in the quality of life is targeted in Stage 4 as depicted by DBT (self-realization and the removal of behaviors that are hindering the happiness and freedom of the individual), however, related implementations and researches have mostly focused on first and second stage behavior targets. There is a scarce of evidence particularly for behaviors that are targeted in stage 4, which is also the concern of preventative mental health.

On the other hand, it is possible to say that DBT skills training is effective in studies and adapted programs implemented in recent years are effective over risky groups as well as over groups recruited from colleges/universities. It is possible to use the training for improving the quality of life and state of well-being and for preventive purposes apart from studies dedicated to realize intervention to different groups as supported by various studies (Pistorello et al. 2012, Engle et al. 2013, Panepinto et al. 2015).

It is reported that symptoms of especially depression and anxiety are very common among Turkish university students (Bostancı et al. 2005, İbrahim et al. 2013). Most common problems experienced by university students are financial and psychological (Yavuzer et al. 2005). Turkish university students reported anxiety (74 %), sleep disorder (68 %), difficulties to cope with new environments (49 %), and difficulties in interpersonal effectiveness (46 %) (Özgülven 1992). Özkan and Yılmaz (1992) reported difficulties in adaptation to university life, 19 % of university students have this problem of adaptation, and counseling as well as psychological support was suggested. Likewise, Korkut-Owen and Demirbaş-Çelik (2018) underline the importance of studies devoted to the improvement of well-being of university students. DBT's framework and its well-established skill set will be very useful to prepare programs to improve well-being of university students. Thus, it is important to test the preventative mental health implementations of DBT skills training and determine the efficacy of implementations in Turkey.

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