**Original paper**

*Archives of Psychiatry Research* 2026;62:149-154

DOI:10.20471/sept.2026.62.02.05
Received May 5, 2025
Accepted after revision October 12, 2025

# DBT Skills Group with Concurrent Psychodynamic Psychotherapy: A Pilot Quasi-Experimental Study from a Single Centre in Indonesia

Darien Alfa Cipta[1,2], Alvin Saputra[1,2], Dyta Ghezanny[2], Natasya Reina[2], Charlotte Alyssia Jonatan[2], Satyadhika Dharma[2], Claudia Hadilianti[2]

[1]Department of Psychiatry, Faculty of Medicine, Universitas Pelita Harapan – Siloam Hospitals Lippo Village, Banten, Indonesia, [2]Faculty of Medicine, Universitas Pelita Harapan – Siloam Hospitals Lippo Village, Banten, Indonesia

**Keywords**

Borderline personality disorder; behavior therapy; psychotherapy

**Abstract**

**Aim:** To evaluate preliminary clinical outcomes of delivering dialectical behavior therapy skills group (DBT-SG) alongside ongoing psychodynamic psychotherapy in patients with borderline personality disorder (BPD) in Indonesia. **Subjects and Methods:** This pilot quasi-experimental study was conducted at a single centre in Indonesia and included ten patients diagnosed with BPD. Participants received DBT-SG alongside individual psychodynamic psychotherapy (IPP) over a 21-week period. Feasibility outcomes included attendance and dropout rates. Clinical outcomes were assessed using the Borderline Symptom List-23 (BSL-23), Patient Health Questionnaire-9 (PHQ-9), and Generalized Anxiety Disorder-7 (GAD-7). **Results:** The intervention demonstrated high feasibility, with a 95 % attendance rate and no dropouts. Significant pre–post improvements were observed in borderline symptoms (BSL-23: 2.0 ± 0.93 to 1.62 ± 0.91; p = 0.003), depressive symptoms (PHQ-9: 14.9 ± 7.93 to 11.1 ± 6.61; p = 0.004), and anxiety symptoms (GAD-7: 12.5 ± 5.93 to 10.3 ± 5.87; p = 0.02). **Conclusions:** Delivering DBT-SG alongside ongoing psychodynamic psychotherapy appears feasible and is associated with preliminary clinical improvement among patients with BPD in an Indonesian clinical setting. Larger controlled studies are needed to further evaluate clinical effectiveness and implementation strategies.

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## Introduction

Borderline Personality Disorder (BPD) is a multifaceted mental health condition characterized by pervasive instability in emotional regulation, interpersonal relationships, self-image, and behavior [1,2].This condition often leads to significant distress and impairment in individuals, posing a substantial public health concern. In Indonesia, an increasing trend in the prevalence of BPD, particularly among young adults, underscores the urgent need for culturally tailored and effective therapeutic interventions. Despite advances in psychotherapeutic techniques, the complexity of BPD necessitates integrative approaches that address the diverse manifestations of the disorder. Dialectical Behavior Therapy (DBT) has

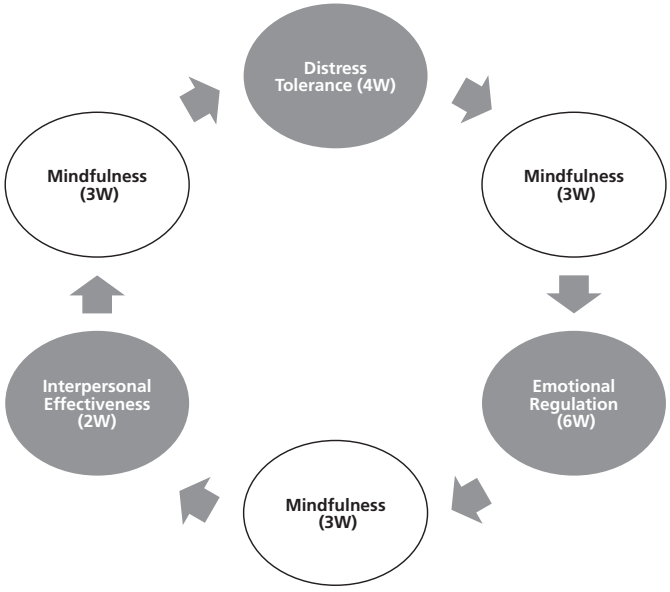
Correspondence to:
Darien Alfa Cipta
Department of Psychiatry, Faculty of Medicine,
University of Pelita Harapan,
MH Thamrin Boulevard 1100,
Tangerang 15811, Indonesia

emerged as one of the most effective interventions, yet its multimodal and intensive nature requires careful adaptation to suit local healthcare settings and sociocultural dynamics (Figure 1) [1-3].

**Figure 1.** Four modalities of DBT (individual, group skills training, in-between sessions contact [phone coaching], and consultation group) [4]




**Figure 2.** DBT-SG schedule in the authors' centre




Research has demonstrated that DBT effectively addresses emotional dysregulation and self-destructive behaviors, which are hallmark features of BPD [4-7]. Simultaneously, individual psychodynamic psychotherapy (IPP) offers a complementary approach by targeting the unconscious conflicts and maladaptive relational patterns that often underlie BPD symptoms. In many real-world clinical settings, particularly when clinicians are primarily trained in contemporary psychodynamic psychotherapy, Dialectical Behavior Therapy Skills Group (DBT-SG) may be delivered alongside ongoing IPP rather than as part of a formally integrated treatment model. This concurrent delivery reflects a pragmatic implementation process during periods of training and service transition, in which structured skills training is introduced while established individual therapeutic practices are maintained. Conceptual discussions by leading figures in DBT and psychodynamic psychotherapy have suggested that these approaches may be compatible when delivered concurrently, particularly in real-world clinical settings where treatment implementation occurs in phases rather than as fully integrated models [8]. However, the feasibility and acceptability of this integrative approach in an Indonesian context remain unexplored, highlighting a critical gap in the evidence base.

The rationale for this study arises from the need to bridge a critical knowledge gap by evaluating whether a combination of DBT-SG and IPP can effectively address the unique needs of Indonesian patients with BPD. By assessing the feasibility and acceptability of this combined approach, the research aims to offer preliminary insights into its potential as a scalable intervention. The concurrent delivery of DBT's structured skills training, alongside IPP's emphasis on relational dynamics during an implementation transition, represents an innovative therapeutic strategy with the potential to benefit patients with BPD across diverse clinical settings [5,6]. However, this approach also raises the question of feasibility when both methods are delivered simultaneously.

While an expanding body of evidence supports the efficacy of DBT and psychodynamic psychotherapy as standalone treatments, limited research has explored their combined application, particularly in low- and middle-income countries. This study addresses this gap by evaluating the feasibility and acceptability of integrating DBT-SG with IPP in an Indonesian context. Such efforts are critical for advancing the field of BPD treatment and ensuring that evidence-based interventions are both accessible and relevant to patients worldwide.

## Subjects and Methods

### Study Design and Setting

This study employed a pilot quasi-experimental pre–post design conducted at Siloam Hospitals Lippo Village, Indonesia, in collaboration with the Faculty of Medicine, Universitas Pelita Harapan. The primary aim of this pilot study was to evaluate the feasibility and explore preliminary clinical signals associated with delivering a DBT-SG alongside ongoing IPP in routine clinical practice.

### Ethical Approval

The study protocol was reviewed and approved by the Institutional Ethics Committee (Institutional Review Board - IRB) of Siloam Hospitals Lippo Village/ Universitas Pelita Harapan (ethical approval number: 082/K-LKJ/ETIK/II/2025). Written informed consent was obtained from all participants before they participated in the study. All procedures were conducted in accordance with the Declaration of Helsinki.

### Participant recruitment

Ten participants were recruited through routine clinical referral to the outpatient psychiatry service at Siloam Hospitals Lippo Village, followed by eligibility screening conducted by a consultant psychiatrist. All participants met DSM-5 diagnostic criteria for borderline personality disorder, as determined through standard clinical assessment.

Eligibility criteria for inclusion were: (1) a primary diagnosis of borderline personality disorder; (2) age 18 years or older; (3) capacity to participate in weekly group skills training alongside ongoing individual psychotherapy; and (4) provision of written informed consent. Participants were excluded if they had: (1) a current psychotic disorder; (2) a substance use disorder requiring acute intervention; (3) severe cognitive impairment; or (4) an inability to commit to the scheduled treatment duration. Comorbid depressive and anxiety symptoms were permitted to reflect routine clinical practice.

As this study was designed as a pilot quasi-experimental feasibility study, formal sample size calculation was not undertaken. A sample size of 10 participants was considered sufficient to evaluate feasibility outcomes and to explore preliminary clinical signals, as pilot studies typically prioritize feasibility over statistical power and commonly employ small cohorts (approximately n = 5–30) to test procedures before larger trials.

### Intervention Protocol

Participants received a combined intervention consisting of IPP and a DBT-SG delivered over 21 weeks. IPP was provided once weekly by consultant psychiatrists trained in contemporary psychodynamic psychotherapy, with sessions lasting approximately 45–60 minutes. Individual therapy focused on facilitating exploration of emotional experiences, recurrent interpersonal patterns, and underlying intrapsychic conflicts, consistent with routine outpatient psychodynamic practice. Interventions were delivered flexibly along the supportive–expressive continuum, as described by Gabbard, and were tailored to patients' clinical needs rather than manualized, reflecting real-world psychodynamic care [9].

The DBT-SG followed a structured, manualized curriculum delivered over 21 weeks. The program comprised four core DBT skills modules: mindfulness, distress tolerance, emotion regulation, and interpersonal effectiveness. Mindfulness was delivered in three separate three-week blocks distributed across the program to reinforce core skills and support integration with other modules. Distress tolerance was delivered over 4 weeks, emotion regulation over 6 weeks, and interpersonal effectiveness over 2 weeks, resulting in a total program duration of 21 weeks (Figure 2).

Each DBT-SG session followed a standardized structure consistent with Linehan's DBT skills training model. Sessions began with a brief mindfulness opening practice, followed by a review of between-session homework and skills practice. After a short break, new skills were introduced through didactic teaching and guided in-session practice, supported by standard DBT handouts and worksheets. Sessions concluded with a brief wrap-up and assignment of between-session practice exercises. The skills group content was delivered in accordance with the DBT skills training manual by Linehan and colleagues [10]. During sessions, each participant was provided with a hard-copy version of the DBT skills training manual in English. All participants were bilingual young adults and followed the English-language materials according to their preference. At the time of the study, an official Indonesian-language version of the DBT skills training handouts was not yet available.

### Therapist Training and Fidelity

The DBT-SG was facilitated by psychiatrists undergoing formal DBT training provided by Behavioral Tech LLC. At the time of the study, the first author (Darien Alfa Cipta) and second author (Alvin Saputra) were enrolled in DBT intensive training and participated in weekly DBT consultation team meetings, consistent with the DBT training model. These meetings functioned as a structured peer consultation process (intervision), focusing on therapists' application of DBT principles, including dialectical strategies, behavioral case formulation, and therapist mindfulness, rather than on detailed review of individual patient cases.

In addition, the therapists received periodic supervision from certified DBT trainers on multiple occasions during the training year. Formal DBT adherence or fidelity rating scales were not employed in this pilot study. This reflects the pragmatic and implementation-focused nature of the study, which aimed to evaluate feasibility and preliminary clinical signals within a real-world clinical setting rather than to test treatment fidelity under controlled trial conditions.

### Assessment Measures

Clinical outcome measures were administered at two time points: at baseline prior to initiation of the DBT-SG and concurrent IPP, and at post-intervention, immediately following completion of the 21-week DBT-SG program. All assessments were completed within routine outpatient clinical visits.

### Feasibility Measures

Feasibility was assessed using session attendance rates and dropout rates across the 21-week intervention period. Attendance was calculated as the proportion of scheduled DBT-SG sessions attended by each participant. Dropout was defined as discontinuation of participation prior to completion of the intervention, operationalized as absence from four consecutive DBT-SG sessions, consistent with standard DBT program conventions.

### Clinical Outcome Measures

Preliminary clinical outcomes were assessed using three standardized self-report measures. BPD symptom severity was measured using the Borderline Symptom List–23 (BSL-23), a 23-item instrument assessing the severity of BPD symptoms, with higher scores indicating greater symptom severity Depressive symptom severity was assessed using the Patient Health Questionnaire–9 (PHQ-9), a 9-item self-report scale measuring depressive symptoms over the preceding two weeks [11]. Anxiety symptom severity was assessed using the Generalized Anxiety Disorder–7 (GAD-7), a 7-item self-report measure with established reliability and validity.

All instruments were administered at baseline and immediately following completion of the intervention. Measures were administered in English. Participants were bilingual young adults with sufficient English proficiency to complete self-report questionnaires and participate in psychotherapy sessions conducted in English. The use of English-language instruments was considered appropriate for this pilot feasibility study conducted in a routine clinical setting.

All measures have demonstrated established psychometric properties in prior clinical research. At the time of the study, an officially validated Indonesian version of the BSL-23 was not available; therefore, the original English versions of the BSL-23, PHQ-9, and GAD-7 were used. This pragmatic approach is consistent with feasibility-focused research involving bilingual participants, and findings were interpreted cautiously in light of potential cultural and language-related measurement bias [12].

Observer-rated measures of interpersonal functioning or clinician-rated BPD severity were not included, as the primary aim of this pilot study was to assess feasibility and explore preliminary symptom-level change using brief self-report instruments.

### Data Analysis

Statistical analyses were conducted to describe feasibility outcomes and to explore preliminary pre–post changes in clinical measures, consistent with the pilot aims of the study. Descriptive statistics (means and standard deviations) were used to summarize feasibility indicators and clinical outcome measures.

The normality of pre- and post-intervention scores was assessed using the Shapiro–Wilk test. Given the pilot nature of the study, pre–post differences in clinical outcome measures (BSL-23, PHQ-9, and GAD-7) were examined using paired t-tests to explore preliminary clinical change. Statistical significance was set at $p < 0.05$. No corrections for multiple comparisons were applied in this exploratory analysis. All analyses were performed using SPSS version 30.

## Results

### Participant Characteristics and Feasibility

Ten adult participants diagnosed with BPD were included in the study. All participants completed the 21-week intervention period. The overall attendance rate for DBT-SG sessions was 95 %, and no participants dropped out during the study.

### Pre–Post Changes in Clinical Outcomes

Preliminary analyses indicated improvements across all measured clinical outcomes following the intervention (Table 1). Mean scores on the BSL-23 decreased from 2.0 ± 0.93 at baseline to 1.62 ± 0.91 post-intervention, representing a statistically significant reduction ($p = 0.003$). Depressive symptoms, as measured by the PHQ-9, also decreased significantly from a mean of 14.9 ± 7.94 to 11.1 ± 6.61 ($p = 0.004$). Similarly, anxiety symptoms assessed using the GAD-7 showed a significant reduction from 12.5 ± 5.93 at baseline to 10.3 ± 5.87 following the intervention ($p = 0.02$).

**Table 1.** Pre- and Post-Intervention BSL-23, GAD-7, and PHQ-9 Mean, Standard Deviation and Paired t-Test Results

| Measure | Time Point | Mean ( ± SD) | Sig.* |
|---|---|---|---|
| BSL-23 Score | Pre-test | 2.00 ( ± 0.93) | 0.003 |
| | Post-test | 1.62 ( ± 0.91) | |
| GAD-7 Score | Pre-test | 12.50 ( ± 5.93) | 0.02 |
| | Post-test | 10.30 ( ± 5.87) | |
| PHQ-9 Score | Pre-test | 14.90 ( ± 7.94) | 0.004 |
| | Post-test | 11.10 ( ± 6.61) | |

*Analysed by paired t-Test

## Discussion

This pilot study examined the feasibility and preliminary clinical outcomes of delivering a DBT-SG alongside ongoing IPP for adults with BPD in an Indonesian clinical setting. Previous work in Indonesia has primarily focused on the development, cultural adaptation, and expert validation of DBT-SG modules, as reflected in published Indonesian clinical research [11]. Empirical data on the combined implementation of DBT-SG with concurrent IPP and standardized clinical outcomes remain limited. To our knowledge, this study represents one of the first Indonesian pilot investigations to evaluate both feasibility indicators and symptom-level changes associated with DBT-SG delivery integrated within routine individual psychotherapeutic care. In the broader Southeast Asian context, emerging studies have demonstrated the feasibility and preliminary effectiveness of brief or adapted DBT skills training across clinical populations [13-17]. However, evidence from Indonesia, particularly within specialist psychiatric services and adult BPD populations, remains sparse. The present study contributes to this growing regional literature by extending DBT implementation research into the Indonesian clinical context.

The intervention demonstrated high feasibility, as reflected by a high attendance rate (95 %) and the absence of dropouts over the 21-week intervention period. In addition, statistically significant pre–post improvements were observed across all measured clinical outcomes, including borderline symptom severity, depressive symptoms, and anxiety symptoms.

Reductions in BSL-23 scores suggest a meaningful decrease in core borderline symptomatology following the intervention. Although the magnitude of change observed in this pilot study should be interpreted cautiously, the consistency of improvement across outcome measures is clinically relevant. Improvements in PHQ-9 and GAD-7 scores further indicate reductions in affective distress, which commonly co-occurs with BPD and contributes substantially to functional impairment.

These findings are broadly consistent with existing literature demonstrating the effectiveness of DBT skills training in addressing emotional dysregulation and associated symptoms in individuals with BPD. Previous studies have shown that DBT-SG interventions can yield moderate improvements, although outcomes are typically more robust when delivered as part of standard, comprehensive DBT [6,7]. The present findings extend this literature by suggesting that DBT-SG may retain clinical value when delivered alongside ongoing psychodynamic psychotherapy, particularly in settings where full implementation of standard DBT is not yet feasible.

Importantly, this study does not propose a formal integrative psychotherapy model. Instead, it reflects a pragmatic implementation approach in which DBT skills training was introduced within a psychodynamic-oriented clinical environment during a period of training and service transition. In such contexts, maintaining established individual therapeutic practices while adding structured skills training may represent a realistic and acceptable pathway toward DBT - informed care. The observed improvements suggest that concurrent delivery of DBT-SG and IPP does not appear to undermine clinical outcomes and may offer complementary benefits. This pragmatic approach aligns with broader movements toward psychotherapy pluralism within psychiatry, which emphasize flexible and context-sensitive application of evidence-based treatments rather than strict adherence to single-modality models [18].

This study has several limitations that should be acknowledged. First, the small sample size and single-centre design limit generalizability and preclude causal inference. Diagnostic procedures were constrained by the absence of inter-rater reliability for DSM-5 borderline personality disorder diagnoses. Second, the lack of a control group and the absence of blinded assessments prevent attribution of observed changes solely to the intervention. The reliance on a single pre–post assessment further limits evaluation of symptom trajectories over time. Third, clinical outcomes relied exclusively on self-report measures (BSL-23, PHQ-9, and GAD-7) administered in English to bilingual Indonesian participants, which may introduce cultural and language-related measurement bias and limit the interpretability of findings [12]. Observer-rated or clinician-rated measures of interpersonal functioning were not included, limiting conclusions regarding functional change, a core treatment target of DBT. From a statistical perspective, the very small sample size (n = 10) and the use of multiple outcome measures without correction increase susceptibility to Type I error; findings should therefore be interpreted as exploratory. Finally, IPP was not manualized, reflecting routine clinical practice but limiting standardization across participants.

Future studies should incorporate larger samples, blinded clinician ratings, observer-rated interpersonal functioning measures, and longitudinal follow-up to more comprehensively assess treatment impact. Despite these limitations, the findings provide preliminary support for the feasibility of delivering DBT-SG alongside psychodynamic psychotherapy in an Indonesian outpatient setting. Future studies employing larger samples, controlled designs, and longer follow-up periods are needed to further evaluate clinical effectiveness and to clarify optimal implementation strategies for DBT skills training within diverse psychotherapeutic frameworks.

In conclusion, this pilot study suggests that delivering a DBT-SG alongside ongoing IPP is feasible and

acceptable within an Indonesian outpatient psychiatric setting. Preliminary improvements in borderline symptoms, depressive symptoms, and anxiety symptoms were observed; however, these findings should be interpreted cautiously, given the small sample size and pilot design. In settings where comprehensive DBT is not yet fully available, concurrent delivery of DBT skills training alongside usual psychotherapeutic care may be feasible as an interim approach. Larger, controlled studies are required to further evaluate clinical effectiveness and implementation.


## Acknowledgment

Special thanks to the B-Tech Trainer team, including Tony DuBose, Carla Walton, Emily Cooney, and Marcus Rodriguez, for their invaluable mentorship. Gratitude also goes to Team 1 DBT Indonesia Intensive Training and the Board Members of the Psychotherapy Section of the Indonesian Psychiatric Association for their support and guidance.

## Conflict of Interest

None to declare.

## Funding Sources

None.


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