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Effects of brief dialectical behavior therapy skills training on Malay-speaking school teachers: A controlled study

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Abstract

School teachers are susceptible to mental health issues due to the challenging responsibilities the teaching profession entails. While several interventions have demonstrated effectiveness in improving teachers' social emotional competencies and mental health outcomes, little work has examined the potential of dialectical behavior therapy–skills training (DBT-ST) in improving teacher outcomes. This study aimed to assess the effects of a five-session, Malay-translated DBT-ST on psychological symptoms (anxiety, depression, stress, burnout), social-emotional competencies, DBT skills use, and dysfunctional coping in a sample of school teachers in East Malaysia. Fifty-three participants were recruited and assigned into DBT-ST or a control group, consisting of attending a mental health talk. Analyses showed that DBT-ST participants reported greater decreases in student-related burnout and dysfunctional coping, and greater increases in DBT skills use compared to the control group from pre- to post-intervention. There were no between-condition differences on changes in other mental health outcomes, though session attendance was linked positively to improvements in several outcomes in the DBT-ST condition. Analyses of post-intervention feedback indicated that brief

DBT-ST was deemed acceptable and feasible among the research participants. In conclusion, DBT-ST holds promise as an intervention to lower student-related burnout and facilitate adaptive coping among school teachers.

Practitioner Points

- Teachers undergoing dialectical behavior therapy (DBT) skills training showed greater decreases in student-related burnout and dysfunctional coping, and greater increases in DBT skills use compared to teachers in the control condition.
- There were no between-condition differences on changes in other mental health outcomes.
- Number of DBT skills training sessions attended was associated with decreases in depressive symptoms and personal burnout, and with increases in DBT skills use.

1 | INTRODUCTION

School teachers have multifaceted responsibilities including educating and supervising students, being in administrative roles as leaders and/or as team members, and as mentors to students and colleagues. Such responsibilities require multitasking and the ability to communicate effectively with people from varying backgrounds, which can be emotionally taxing, especially in time-poor contexts (Hargreaves, 1998). Therefore, it is not surprising that teachers have been found to be at risk of experiencing mental health issues due to the imbalance of emotional demands and resources its profession entails (Iancu et al., 2018; Marques et al., 2019; McCarthy et al., 2016). A systematic review involving 49 independent samples of secondary school teachers recruited internationally found that 28.1% of school teachers experience severe emotional exhaustion, whereas close to 40% reported high levels of depersonalization and low levels of personal accomplishment respectively (García-Carmona et al., 2019).

In Malaysia, the prevalence of burnout among teachers has been found to be as high as 10.7%, and fourfold in females (Anita et al., 2014), with the prevalence of depression, anxiety and stress ranging from 32% to 68% (Othman & Sivasubramaniam, 2019). The COVID-19 pandemic forced further rapid adaptation to online modes, precipitating increased stress, anxiety (Dhawan, 2020; Pressley, 2021; Sokal et al., 2020), and burnout (Westphal et al., 2022). Compromised mental well-being in teachers can negatively impact students' academic performance and wellbeing, quality of education provided, and classroom climate (Jennings & Greenberg, 2009; Justo et al., 2018). Past studies have demonstrated negative associations between teachers' burnout and students' motivation and engagement, academic achievements, Student–teacher relationship, and retainment of students (Harding et al., 2019; Krane et al., 2016; Madigan & Kim, 2021; Wong et al., 2017).

To promote a conducive learning environment and address mental health needs among school teachers, interventions based on the social and emotional learning (SEL) framework have been increasingly implemented in

schools (Garner et al., 2018; Mahoney et al., 2018). The SEL framework describes several competencies corresponding with self-awareness, self-management, relationship skills, social awareness, and responsible decision making, which are deemed as important to facilitate effective teaching and self-care among school teachers (CASEL, 2017). In one study, a mindfulness-based SEL program was found to be effective in improving emotional competence in a sample of preservice teachers (Garner et al., 2018), although it is unclear the extent to which the findings would generalize to school teachers more generally. Within the broader literature, teachers with higher social-emotional competencies have been found to demonstrate greater empathy, with this relationship mediated by teaching self-efficacy (Hen & Goroshit, 2016). Social-emotional competencies have also been negatively associated with burnout among school teachers (Oberle et al., 2020). Therefore, interventions aiming to improve social emotional competencies in school teachers may result in improvements in teacher burnout and mental health symptoms, and subsequently lead to an improved teaching and learning experience in the classroom.

Of several SEL-based interventions that have been developed (e.g., Brackett et al., 2012; Garner et al., 2018; Jennings, 2016), one promising intervention is dialectical behavior therapy (DBT), a cognitive behavioral intervention aiming to improve regulation of emotions and behaviors (Linehan, 1993). DBT is a comprehensive treatment originally developed to treat suicidality in borderline personality disorder (BPD; Linehan, 1993), and has since been adapted to improve mental health outcomes in a variety of clinical and nonclinical populations (Cavicchioli, Vassena et al., 2021; Cavicchioli, Ramella et al., 2021; Dimeff & Linehan, 2008; Wisniewski & Ben-Porath, 2015; O'Mara et al., 2021; Zargar et al., 2019). DBT skills training (DBT-ST) is a component of DBT involving teaching of four skills modules–mindfulness skills, emotion regulation skills, distress tolerance skills, and interpersonal effectiveness skills (Linehan, 1993). It has been proposed that DBT-ST could enhance social and emotional competencies outlined in the SEL framework (Justo et al., 2018). Mindfulness and emotion regulation skills may facilitate greater self-awareness, more effective self-management, and responsible decision making. Distress tolerance skills may increase teachers' ability to cope with stressful situations at work without resorting to maladaptive coping strategies, whereas interpersonal effectiveness skills are relevant for developing social competencies and building positive relationships.

To date, several studies have evaluated the evaluated the effects of DBT-ST as a standalone treatment. A review by Valentine et al. (2015) found preliminary evidence for the effects of DBT-ST in treating psychological symptoms in several clinical conditions, such as major depressive disorder binge eating disorder. In one study involving patients with BPD, DBT-ST was found to be superior to standard group therapy in reducing depression, anxiety and general psychiatric symptoms (Soler et al., 2009). In another study involving adults with emotion dysregulation issues, a 16-week DBT-ST program was found to be effective in reducing emotion dysregulation and anxiety, and increasing DBT skills use (Neacsiu et al., 2014). In nonclinical populations, brief adaptations of DBT-ST (lasting six sessions) has been found to be effective in increasing DBT knowledge and reducing personal and work-related burnout in pediatrics nurses (Haynos et al., 2016). Participation in a DBT-ST program has also been associated with improvements in emotion dysregulation, stress reactivity, and several interpersonal outcomes in a study involving caregivers of individuals with behavioral disorders (Wilks et al., 2017). Taken together, these findings suggest that learning DBT skills may bring about benefits in terms of improved emotion regulation and reduced burnout, and the benefits could extend to school teachers and educators, given competing demands and emotional challenges involved in the delivery of their work.

To date, two uncontrolled studies have examined the potential of DBT-ST as an intervention to improve mental health in school teachers. Justo et al. (2018) evaluated outcomes following a brief, four-session DBT-ST program that incorporated the SEL framework in a sample of school teachers in Brazil, and found that participants demonstrated improvements in educational social skills in terms of ability to present, demonstrate, and assess interactively. The study's design however is limited by a small sample and a lack of a control group, which precludes causal conclusions regarding the effects of DBT-ST in the sample. Further, the study investigated changes in social-emotional competencies, without assessing other mental health outcomes. In another prospective study, Shernoff et al. (2022) examined the implementation of an eight-session, virtually-delivered DBT-ST program in a sample of 39 teachers and school personnel in high poverty schools in the United States. Results indicated that there were significant decreases in stress and dysfunctional coping, and increases in DBT skill use from pre- to

post-intervention. There were no significant changes in depression and anxiety, although it was found that high stress participants were more likely to attend the skills group compared to low stress participants. While the study's design is limited by a lack of a control group, it demonstrated the promise of DBT-ST in improving coping and selected mental health outcomes in school teachers.

To date, no study has yet evaluated the effects of DBT-ST on teachers' mental health in the context of a controlled trial. Further, the majority of studies evaluating the effects of DBT-ST have been carried out in North America or Europe, and there is a paucity of research examining the implementation of DBT-ST in nonclinical populations in an Asian context. In this study, we aimed to examine the effects of DBT-ST on psychological symptoms (depression, anxiety, stress, and burnout), social-emotional competencies, DBT skills use, and dysfunctional coping in a sample of school teachers in a rural district in East Malaysia, where access to mental health resources is limited. We hypothesized that participants attending DBT-ST would report greater improvements burnout and social-emotional competencies, compared to a control group attending a mental health talk. We also predicted that DBT-ST participants would demonstrate greater improvements in the use of DBT skills and decreases in dysfunctional coping compared to control group participants. Given mixed findings in relation to DBT-ST's effects on psychological symptoms (Shernoff et al., 2022), it was an exploratory question whether participation in the DBT-ST would lead to improvements in depressive symptoms, anxiety, and stress.

2 │ METHODS

2.1 │ Participants

A total of 56 participants were recruited from several public primary and secondary schools in Kudat, a small, remote town located in Sabah, Malaysia. Participants were recruited by Kudat's District Education Office. They would be eligible for the study if they (1) were working as school teachers involved in student counseling and affairs and (2) aged 18 years old and above. Approximately more than half of the recruited participants were female ($n = 34$; 60.71%) and taught in a secondary school ($n = 34$; 60.71%). Participants' age ranged from 25 to 58 years old ($M = 42.89$ years; $SD = 8.36$ years), and their teaching experience ranged from 3 months to 32 years ($M = 14.66$ years; $SD = 9.98$ years). The majority of participants ($n = 44$; 78.57%) held a Bachelor's degree, eight participants (14.29%) had a Master's degree, three participants (5.36%) had a Diploma, and one participant (1.79%) had a PhD degree.

Assuming an alpha level of .05 and a small effect size (0.20), sample size calculation indicated that 52 participants would be required to detect a significant Time by Group interaction effect, using a mixed analysis of variance analytic approach.

2.2 │ Procedure

This study was a collaborative project involving University Malaysia Sabah (UMS) and Monash University Malaysia. The procedure of this study was approved by the UMS Research Ethics Board and Monash University Research Ethics Committee (#35250). All participants provided informed consent before participating in the study. Participants were assigned by the District Education Office to the intervention (DBT-ST) group ($n = 33$) or the control group, which consisted of attending a 3-h mental health talk ($n = 23$). Seven participants in each condition did not attend either Time 1 or Time 2 assessment, leaving 44 participants with complete data (DBT-ST: $n = 27$; Control: $n = 17$). Figure 1 provides a flowchart of the study procedure.

Time 1 data collection was carried out a week before the first intervention session for the intervention group (DBT-ST), and the mental health talk for the control group. Participants were gathered in a conference room, and
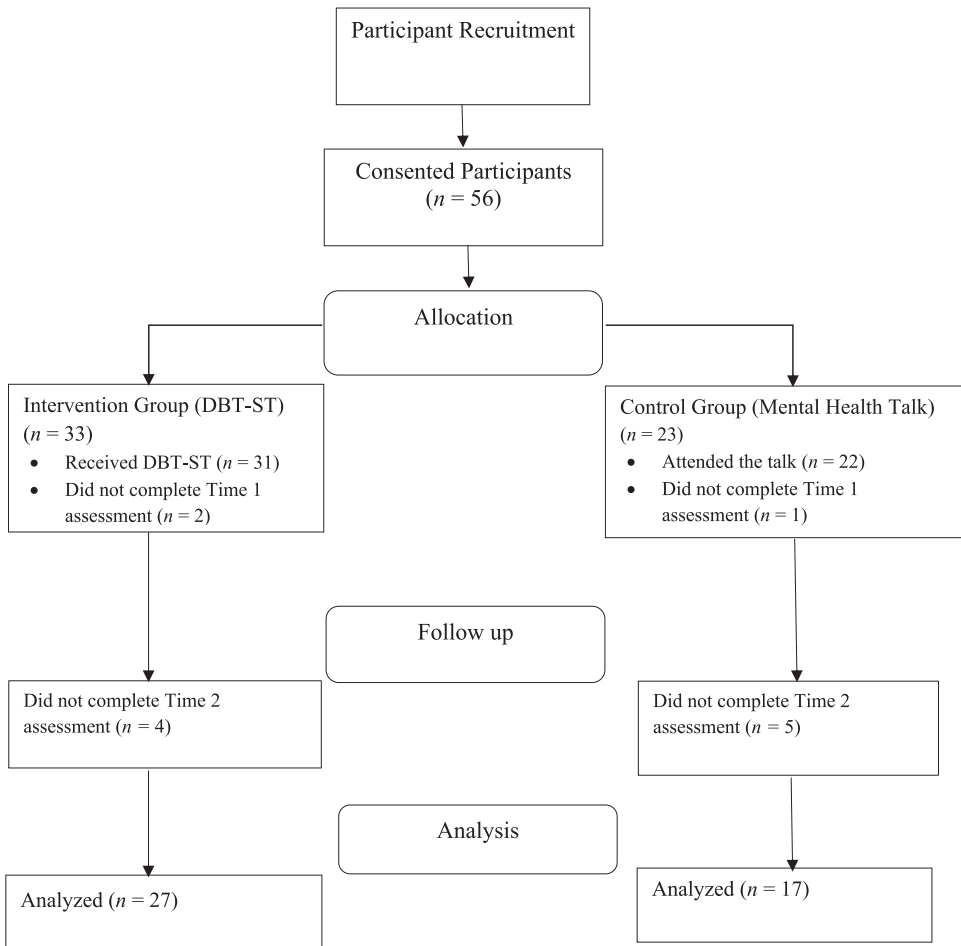
FIGURE 1 Study procedure.

the research coordinator provided a brief explanation of the study and its protocol. Participants were then directed to a link that included the study's information sheet and consent form, and were given an opportunity to ask questions about the study before signing the consent form. Upon providing consent, participants were redirected to a battery of self-report questionnaires administered via Qualtrics. Time 2 data collection was carried out using the same procedure approximately a week after the last (fifth) DBT-ST session. For the DBT-ST participants, an open-ended survey was additionally administered to obtain participants' feedback on the DBT-ST sessions.

2.2.1 | Intervention group (DBT-ST)

The intervention consisted of 5 weekly, 3-h sessions of DBT-ST. The intervention was delivered by three psychiatrists, one medical officer, and one clinical psychologist, under the supervision of a doctorally-trained clinical psychologist with intensive training in DBT. Of the five skills group leaders, three completed online DBT intensive training with PsychWire (a training company delivering online DBT training courses), whereas one attended a DBT skills for adolescents training course with PsychWire. All skills group leaders were based in Kota Kinabalu, Sabah's capital city that is located approximately 3 h' drive away from Kudat, the study site.

The DBT-ST sessions were delivered in two parallel groups, with between 15 and 16 participants in each group. Each skills group was led by two co-leaders. The groups were delivered in Malay (the national language in Malaysia) as most of the participants spoke Malay as the first language, despite also having fair or adequate proficiency in English. The intervention consisted of selected DBT skills from each of the four core modules based on Linehan's DBT-ST manual (Linehan, 2015; see Table 1 for a session-by-session outline of the DBT skills group), and homework involving practicing specific DBT skills would be assigned following each session. A DBT skills group workbook was compiled based on handouts and worksheets available from Linehan (2015)'s DBT Skills Training manual. The handouts and worksheets were translated into Malay by several staff from UMS' Department of Psychiatry, with permission by Guilford, the publisher of Linehan (2015)'s DBT skills training manual.

Due to resource limitations (limited funding available to send the skills group leaders to the study site weekly), the first and last intervention sessions were delivered in person, whereas the remaining three sessions (Sessions 2–4) were delivered virtually. As per the standard DBT skills training protocol, each session would begin with a brief mindfulness practice. Participants would then proceed with homework review, during which they described how they practiced skills taught in the previous week. The second half of the session would consist of teaching of new DBT skills. Efforts were made to contextualize the skills taught for application in teachers' work setting (e.g., use of DEAR MAN, a DBT interpersonal skill in managing interpersonal demand at work). Participants were given attendance certificates after they completed the DBT-ST sessions.

2.2.2 | Control group (mental health talk)

A mental health talk was given to the control group in Malay on the same day as the first DBT-ST session. The mental health talk focused on the awareness of mental illnesses (depression and anxiety) and suicidality in Malaysia, along with a review of common symptoms and treatments. The mental health talk was conducted by two medical doctors from UMS Hospital. In addition to psychoeducation about common mental health symptoms, the talk included a demonstration of a deep breathing practice and a grounding exercise.

2.3 | Measures

Study measures were administered in English (using originally published scales), accompanied by Malay translations for participants as an additional reference.[1] At Time 1, participants were presented with a demographic form to assess sociodemographic information, in particular gender, ethnicity, age, highest education, years of teaching experience, and types of schools that the participants taught in. At both Time 1 and Time 2, all outcome measures were administered.

To measure participants' psychological symptoms, the 21-item Depression, Anxiety, and Stress Scales (DASS-21) were administered (Lovibond & Lovibond, 1995). The scales measure the severity of depressive, anxiety and stress symptoms in the past week, and items are rated on a 4-point Likert scale, ranging from 0 (*Never*), 1 (*Sometimes*), 2 (*Always*), to 3 (*Almost always*). In addition to the original, English version, the Malay translated version of DASS-21 was administered for additional reference by the participants. The scale has been validated in a Malaysian undergraduate sample and demonstrated high internal consistency (Ahmad et al., 2018). In this study, the internal consistencies for the depression, anxiety, and stress subscales were 0.73, 0.82, 0.74 respectively.

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[1]In the event where a measure has been translated and validated in the Malay language (i.e., Depression, Anxiety, and Stress Scales- 21, Copenhagen Burnout Inventory), the existing, translated version would be used. In the event where a validated, translated version was not available, the translations would be manually carried out by the research team and checked for accuracy by Malay-speaking research members.

TABLE 1 Outline of the five-session DBT skills group.

Session	Module	Content
1	Mindfulness	DBT skills training: Introduction and goal setting
		Linking of DBT skills to the social emotional learning (SEL) framework
		Wise mind
		"What" skills
		"How" skills
2	Emotion regulation	Understanding emotions; describing emotions
		ABC PLEASE skills
		Build mastery
		COPE ahead
3	Distress tolerance	Opposite action
		Crisis survival skills: distracting; self-soothing; IMPROVE
		Radical acceptance
		Willingness; half smile; willing hands
4	Interpersonal effectiveness	Objectives effectiveness: DEAR MAN
		Relationship effectiveness: GIVE
		Self-respect effectiveness: FAST
5	Interpersonal effectiveness (cont'd) and Wrap Up	Validation
		feedback for the skills group

Participants' level of burnout was measured using the 19-item Copenhagen Burnout Inventory (CBI; Kristensen et al., 2005). The measure consists of three subscales, namely personal burnout, work-related burnout, and client-related burnout. For the client-related burnout subscale, items referencing "clients" in the subscale were replaced by "students" to make the construct more relevant for the teachers recruited in this sample (thus this subscale is renamed "student-related burnout"). Items were rated on a 5-point Likert scale, spanning from 0 (*Never*), 25 (*Seldom*), 50 (*Sometimes*), 75 (*Often*), to 100 (*Always*). Additionally, the Malay-translated version of CBI was administered for additional reference. The scale has been validated in a Malaysian medical students' sample and demonstrated high internal reliability (Chin et al., 2018). In this study, the internal reliability for personal burnout, work-related burnout, and student-related burnout subscales were 0.85, 0.73, and 0.64 respectively.

The Self-Assessing Social and Emotional Instruction and Competencies for Teachers was utilized to measure participants' social and emotional competencies (SASEIC; Yoder, 2014). Only Part B (corresponding to teachers' self-report SEL) from Section 1 (Social Interaction Assessment) and Section 2 (Instructional Interaction Assessment) were used. The 44-item scale assesses items related to self-awareness, self-management, relationship skills, social awareness, and responsible decision making, and all items are rated on a 4-point Likert scale, ranging from 1 (*Strongly agree*) to 4 (*Strongly agree*). The scale's internal reliability in this study was excellent ($\alpha = .96$).

The 59-item Dialectical Behavior Therapy–Ways of Coping Checklist (DBT-WCCL) was administered to measure participants' use of DBT skills and dysfunctional coping strategies for the past month (Neacsiu et al., 2010). Items are split into two subscales (of DBT skills use and dysfunctional coping strategies respectively) and rated on a 4-point Likert scale, ranging from 0 (*Never used*) to 3 (*Regularly used*). In this study, the internal reliability for the DBT skills use and dysfunctional coping subscales were 0.82 and 0.86 respectively.

RIGHTSLINK

2.4 | Data analysis

Data was analyzed using IBM SPSS Statistics. Before data analyses, all dependent variables were checked on their normality of distributions. Transformations were performed for any continuous dependent variables that were skewed. Missing values of individual scale items were replaced using the average score of the subscale that the item(s) belong to. Only data from participants who completed both Time 1 and Time 2 assessments were included in the primary analysis.

We first compared the baseline characteristics between the intervention group and the control group using chi-square tests (for categorical variables) and independent-sample t-tests (for continuous variables). Next, linear regression analyses were carried out to examine whether any baseline characteristics (gender, ethnicity, age, highest education, years of teaching experience, and type of schools taught) predicted change in any outcome variable, and therefore should be controlled for in subsequent analyses. Time 2 score of each variable were regressed against the corresponding Time 1 score and each candidate covariate to examine if it predicted change on any outcome variables.

For the primary analyses, we conducted hierarchical regression, where Time 2 scores of the outcome variables were regressed on their corresponding Time 1 scores, followed by any identified covariate(s), and intervention group was entered as a last predictor. We also conducted pair-sample t tests within each group to assess change in each outcome variables from Time 1 and Time 2. Correlational analyses were also performed to analyze the relationship between number of DBT-ST sessions attended and changes in each outcome variables. Lastly, feedback from survey was analyzed to assess the acceptability of the DBT-ST program among the participants.

3 | RESULTS

3.1 | Baseline comparison between the intervention group and the control group

Table 2 presents the demographic characteristics across the DBT-ST group and the control group. Across both groups, age ($t(42) = -5.45$), years of teaching experience ($t(42) = -5.47$, $p < .001$), and type of school taught ($X^2(1) = 4.86$, $p = .027$) were found to be significantly different. Participants in the control group were older and more years of teaching experience than the DBT-ST group. There were more participants from the intervention condition who were teaching in secondary schools compared to those in the control group. Both groups did not differ on any other demographic or outcome variables at baseline, $p > .05$.

3.2 | Analysis of potential covariates

Given that age, years of teaching experience, and type of school taught differed between both groups, these variables were tested as potential covariates to examine if they predicted change in each outcome variable and therefore would need to be controlled for in the primary analyses. Age was found to be a significant predictor of change in social and emotional competencies from Time 1 to Time 2 ($\beta = -0.07$), $p = .017$. Meanwhile, type of school taught was a significant predictor of change in anxiety ($\beta = -1.43$, $p = .036$) and stress symptoms ($\beta = -1.31$, $p = .034$), along with DBT skills use ($\beta = .09$, $p = .048$). Teaching experience did not predict change in any of the outcome variables. Therefore, age and type of school taught were controlled for in subsequent analysis examining the effect of group (intervention vs. control) on change for the respective outcome measures.

TABLE 2 Sample characteristics.

Variables	Intervention (*n* = 33) M (SD)	Control (*n* = 23) M (SD)	All (*N* = 56) M (SD)
Age	38.82 (7.27)	48.74 (6.11)	42.89 (8.36)
Teaching experience (in years)	9.21 (8.32)	22.48 (6.30)	14.66 (9.98)
	Percentage (%)	Percentage (%)	Percentage (%)
Gender			
Male	30.30	47.83	37.50
Female	66.67	52.17	60.71
Prefer not to say	3.03	0	1.79
Ethnicity			
Malay	9.09	0	5.36
Chinese	0	13.04	5.36
Bumiputera Sabah	78.78	78.26	78.57
Bumiputera Sarawak	3.03	0	1.79
Others	9.09	8.70	8.93
Highest education			
Diploma	0	13.04	5.36
Bachelor's degree	81.82	73.91	78.57
Master's degree	15.15	13.04	14.29
Others	3.03	0	1.79
Type of school taught			
Primary school	27.27	56.52	39.29
Secondary school	72.73	43.48	60.71

3.3 | Effects of DBT-ST on outcome variables

Results using linear regression analyses indicated that assignment to the DBT-ST condition, relative to the control condition, predicted significant improvements in DBT skills use, $\beta = -0.29$, $p = .044$, and dysfunctional coping, $\beta = .24$, $p = .037$, as well as decreases in student-related burnout, $\beta = .31$, $p = .012$. Meanwhile, there were no between-condition differences on changes in depression, anxiety, stress, social emotional competencies, personal burnout, or work-related burnout, from Time 1 to Time 2. Table 3 presents the descriptive and test statistics for the analyses.

3.4 | Within-group changes in outcome variables

Results from paired sample t tests indicated that participants in the DBT-ST condition reported significant increases in social and emotional competencies, and DBT skills use, and significant decreases in student-related burnout and dysfunctional coping from Time 1 to Time 2. There were no significant changes in anxiety, depression, stress,

TABLE 3 Descriptive and test statistics for outcome variables across the intervention and control groups.

Variable	Intervention		Control		Group Effect			
	Time 1	Time 2	Time 1	Time 2	β	ΔR²	p	f²
Social emotional competencies	3.11 (0.36)	15.03 (1.66)	3.12 (0.28)	14.02 (1.67)	−.15	.01	.392	0.01
Depression	2.74 (3.29)	1.33 (2.66)	3.65 (4.70)	2.59 (4.23)	.11	.01	.357	0.02
Anxiety	3.48 (5.16)	3.41 (5.46)	6.00 (4.85)	4.00 (3.61)	−.13	.02	.334	0.02
Stress	5.56 (5.09)	3.63 (4.26)	6.47 (4.16)	5.65 (3.18)	.17	.03	.285	0.03
Personal burnout	28.86 (14.80)	25.15 (15.48)	28.19 (14.99)	25.00 (16.86)	.01	.00	.925	0.00
Work-related burnout	20.90 (14.17)	18.12 (10.19)	21.22 (13.97)	20.38 (15.40)	.08	.01	.511	0.01
Student-related burnout	21.91 (12.80)	16.20 (9.55)	21.57 (10.95)	23.04 (12.60)	.31	.10	.012	0.20
DBT skills use	2.27 (0.20)	2.41 (0.19)	2.21 (0.28)	2.15 (0.40)	−.29	.07	.044	0.11
Dysfunctional coping	1.30 (0.44)	1.12 (0.40)	1.19 (0.40)	1.24 (0.37)	.24	.05	.037	0.11

TABLE 4 Pairwise comparisons between time 1 and time 2 for the intervention group and the control group.

Variable	Intervention					Control				
				95% CI					95% CI	
	t	p	d	Lower	Upper	t	p	d	Lower	Upper
Social-emotional competencies	−40.09	<.001	1.55	−12.53	−11.31	−29.33	<.001	1.53	−11.69	−10.11
Depression	1.97	.060	3.71	−0.06	2.88	2.17	.046	2.01	0.02	2.09
Anxiety	0.07	.944	5.45	−2.08	2.23	2.10	.052	3.94	−0.02	4.02
Stress	1.57	.128	6.36	−0.59	4.44	0.72	.480	4.69	−1.59	3.24
Personal burnout	1.62	.118	11.92	−1.01	8.42	1.04	.314	12.63	−3.31	9.68
Work-related burnout	1.11	.276	12.97	−2.35	7.91	0.32	.750	10.68	−4.65	6.33
Student-related burnout	3.07	.005	9.68	1.88	9.54	−0.56	.586	10.92	−7.08	4.14
DBT Skills use	−3.74	<.001	0.19	−0.21	−0.06	−0.52	.608	0.41	−0.16	0.27
Dysfunctional coping	2.91	.007	0.32	0.05	0.30	−0.67	.515	0.29	−0.20	0.10

personal burnout, and work-related burnout from pre to postintervention in this condition. Meanwhile, participants in the control group reported significant increases in social and emotional competencies, and decreases in depression symptoms. There were no significant changes in the other outcome variables in the control group. Table 4 presents the descriptive and test statistics for the analyses.

3.5 | Association between DBT-ST session attendance and changes in outcome variables

On average, participants attended 4.41 sessions (SD = 1.10 sessions) of DBT-ST. A total of 66.7% of participants attended all five sessions of the program. Correlational analyses were carried out to analyze the relationship

between number of DBT-ST sessions attended and changes in each outcome variable. Before the analyses, change scores for each outcome variables were calculated by subtracting Time 1 scores from Time 2 scores. Results showed that the number of DBT-ST sessions attended was significantly associated with decreases in depressive symptoms ($r = -.42$, $p = .028$), decreases in personal burnout ($r = -.59$, $p = .001$), and increases in DBT skills use ($r = -.61$, $p < .001$). There was no association between number of sessions attended and changes in social and emotional competencies, anxiety, stress, work-related burnout, student-related burnout, DBT skills use, and dysfunctional coping.

3.6 | Analyses of feedback regarding the DBT-ST group

Overall, DBT-ST participants reported they were moderately satisfied with the DBT-ST provided ($M = 4.70$, $SD = 0.47$, on a 1–5 scale). The overall mean score for perceived helpfulness of the DBT-ST was 4.83 ($SD = 0.37$, on a 1–5 scale). All participants reported that they would be interested to join another DBT-ST session in the future.

Qualitative data obtained from the survey was organized and established into two categories: reflections and suggestion for improvements. Twenty-two participants provided qualitative feedback regarding their experience participating in the skills group. Of these participants, 10 (45.45%) reflected that skills introduced were useful in daily activities and beneficial when interacting with others. Three participants (13.64%) reported that the skills contributed to a greater understanding of oneself and aided in executing teachers' responsibilities. With regard to suggestions for improvements, four participants (18.18%) suggested for an extension of intervention duration and expressed a preference for full, in-person delivery of skills group. Participants also reported that contents were more easily understood in sessions when the intervention was delivered in person. The 10 (45.45%) participants reported finding mindfulness skills to be the most beneficial, whereas 5 (22.73%) indicated interpersonal effectiveness skills to be the most helpful. Distress tolerance was endorsed as the most helpful skill by three participants (13.64%), and one participant (4.55%) reported that emotional regulation skills were the most helpful.

4 | DISCUSSION

This study aimed to assess the effects of a brief DBT-ST program on psychological symptoms, social-emotional competencies, DBT skills use, and dysfunctional coping in a sample of school teachers in Malaysia. Results showed that compared to the control group, teachers receiving DBT-ST reported greater decreases in student-related burnout and dysfunctional coping, and greater increases in DBT skills use from pre- to post-intervention. Changes in social and emotional competencies, depression, anxiety, stress did not differ significantly between the intervention group and the control group.

Partially supporting the hypothesis, DBT-ST led to significant decreases in student-related burnout, but not personal and work-related burnout. This suggests that DBT-ST is effective at supporting teachers in managing burnout associated with working with students. The finding is in contrast to those reported by Haynos et al. (2016), who found that DBT-ST was effective at lowering personal and work-related burnout, and not client-related burnout in a sample of mental health staff. The discrepancy in the findings may be in part attributed to the fact that that personal and work-related burnout in our study's sample were much lower than the sample in Haynos et al. (2016), suggesting that floor effect may have accounted for the lack of effects observed in our sample. Further, Haynos et al. (2016) delivered a longer DBT-ST program (six sessions over 12 weeks), which may facilitate more intensive or consolidated skills learning that translates into benefits in terms of personal and work-related burnout.

Interestingly, no differences were observed on changes in depression, anxiety, and stress symptoms between the intervention group and the control group. This null finding could be due to the fact that levels of depression, anxiety, and stress in the sample were within the normal range to begin with, and that DBT-ST may benefit those

with greater psychological symptoms. Within the larger literature, DBT-ST has been shown to have a more consistent effect in lowering psychopathological symptoms among clinical or subclinical populations (e.g., Neacsiu et al., 2014; Soler et al., 2009) as opposed to nonclinical populations. Consistent with our findings, Shernoff et al. (2022) also did not find an effect of DBT-ST on depression or anxiety in a sample of educators, even though there was a significant decrease in stress among participants attending the program. Notably, in the present study, within-group analyses demonstrated declines in depressive symptoms within *both* the DBT-ST group and the control group (with changes in the control group reaching statistical significance), suggesting that participants who attended the mental health talk might have gained some benefits in terms of managing symptoms of depression.

The finding that DBT-ST did not lead to differential improvements in social-emotional competencies is contradictory to past findings (Justo et al., 2018), which demonstrated an association between participation in DBT-ST and improvements in educational social skills. It is plausible that the relatively short duration of the intervention precluded more pronounced changes to be observed; however, results from within-group analyses did demonstrate significant improvements in social-emotional competencies for both conditions. It is unclear what may account for the changes, especially since the control group attended only a mental health talk that did not include content specific to social-emotional learning. Meanwhile, we cannot rule out the possibility that cross-group interactions might have happened, as some teachers in the intervention group and the control group worked in the same school(s). Thus, sharing of DBT skills-related content may have happened across the conditions, which may account for the improvements observed within each condition.

As hypothesized, DBT-ST participants reported significantly greater increases in DBT skills use and decreases in dysfunctional coping compared to the control group. These findings suggest that the program was effective in facilitating use of DBT skills, and in decreasing maladaptive coping strategies among the participants, likely due to the program's emphasis on homework practice in addition to didactic teaching. The findings correspond with past studies demonstrating that participation in DBT skills training is associated with increased skills use in treatment seeking adults (Kells et al., 2020) and college students with emotion regulation difficulties (Neacsiu et al., 2014). Further, the number of DBT-ST sessions attended was found to be associated with decreases in depressive symptoms and personal burnout, and increases in DBT skills use, indicating a dose response relationship between exposure to DBT skills training and selected outcomes. Notably, participants attended 4.41 sessions out of six sessions, indicating an acceptable completion rate (73.5%), which is higher than rates reported in other studies involving clinical or subclinical populations, with a longer DBT-ST program (e.g., Neacsiu et al., 2014).

Based on data acquired from the post-intervention survey, teachers reported moderate satisfaction with the DBT-ST program, and perceived benefits in terms of increased self-awareness and acquisition of skills in coping with stressors in the context of work and everyday life. Meanwhile, a number of participants expressed a preference for a longer skills training program, as well as delivery of skills training in a full, in-person format. Based on the feedback, extending the duration of DBT skill training may yield greater benefits for school teachers, in terms of improved mental health outcomes. Meanwhile, adoption of a fully in-person delivery format would require an expansion of resources in terms of increasing the availability of DBT-trained clinicians in the region, which at present remains scarce in Malaysia. While an online or hybrid delivery modality allows the training to be more accessible to individuals living in remote areas, benefitting from this training format requires resources such as having stable internet connections and devices suitable for online learning, which may or may not be available in certain areas in Malaysia. Based on the research team's anecdotal observations, several participants struggled with participating in the online DBT-ST sessions (Sessions 2-4) due to unstable internet connections at home. These challenges were addressed during the study by inviting these participants to join the online skills training sessions from the District's Education Office, where stable internet connection was available. Despite these challenges, the findings suggest that a brief, Malay-translated DBT-ST protocol is largely feasible and acceptable among school teachers.

This study is characterized by several strengths. Inclusion of a control group allowed us to assess the effects of DBT-ST on mental health outcomes more rigorously, in contrast to previous research that employed a prospective

design without a control group (Justo et al., 2018; Shernoff et al., 2022). Notably, however, the control group was not randomly assigned, which means that self-selection bias could not be ruled out as a factor that may explain the effects of the DBT-ST program. Analytically, we compared baseline differences between the intervention group and the control group, and systematically assessed for potential covariates to be controlled for in the primary analyses. This enabled the analyses to account for the effects of baseline differences on changes in the outcome variables. Lastly, this study is the first to assess the effects of a Malay-translated DBT-ST program on teachers in Malaysia, and adds value to the literature pertaining to cross-cultural and linguistic adaptations of DBT skills training.

In terms of limitations, this study is limited by a smaller-than-ideal sample size, as several participants dropped out of the study at baseline and during the Time 2 assessment, resulting in a slightly under-powered sample. Arguably, the use of a hybrid modality (in person and virtual) in the delivery of DBT-ST is a limitation, as the modality made it challenging to deliver teaching materials consistently across sessions. The lack of a consistent delivery modality may have reduced the efficacy of the intervention. On the flipside, the study also demonstrated the feasibility of using a hybrid modality to deliver DBT-ST sessions, which could be valuable in a context where there is a lack of access to DBT-trained clinicians on site. The fact that participants in the study possessed variable English proficiency warrants the administration of study measures bilingually, and two Malay-translated scales used in the study (SASEIC and DBT-WCCL) have not been psychometrically validated, which limits the interpretation of the findings. Nonetheless, the translated scales were checked for accuracy by Malay-speaking members of the study team before their administration to the participants. Lastly, future research could benefit from aligning the delivery of DBT skills training with existing models of professional development (e.g., Joyce & Showers, 2002). For example, it will be of value to examine whether peer coaching, in addition to theory, skills demonstration, and practice, would enhance teachers' learning of DBT skills and ability to incorporate skills teaching in the context of classroom or student counseling work.

Overall, the findings indicate that brief DBT-ST is effective at improving selected mental health outcomes and promoting adaptive coping among school teachers in this study. Contrary to prediction, DBT-ST did not result in greater improvements in depressive symptoms, anxiety, stress, or social-emotional competencies among the participants, even though the data revealed a positive association between session attendance and selected outcomes (i.e., depressive symptoms, personal burnout, and DBT skills use) among teachers attending the program. Future research could evaluate whether a longer or more intensive DBT-ST program would yield greater mental health benefits among school teachers. It is also plausible that the effects of DBT-ST may emerge more in a sample with higher baseline symptoms of psychological distress, as suggested by previous research demonstrating the benefits of DBT-ST in clinical or subclinical samples (Neacsiu et al., 2014; Valentine et al., 2015). Considering known associations between teachers' mental health and student-related learning outcomes (Harding et al., 2019; Krane et al., 2016), future work could evaluate the extent to which benefits experienced by school teachers translate into an improved classroom or learning experience for students. Lastly, use of a randomized controlled design with a larger sample would enable stronger causal conclusions regarding the effects of DBT-ST on mental health outcomes among school teachers.

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CONFLICT OF INTEREST STATEMENT

The authors declare no conflicts of interest.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from the corresponding author upon reasonable request.

ETHICS STATEMENT

The procedure of this study was approved by the UMS Research Ethics Board and Monash University's Research Ethics Committee (#35250).

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