Original Article

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Effects of Dialectical Behavior Therapy Based Mindfulness and Interpersonal Effectiveness Training on Anti-Bullying Awareness and Bystander Intervention Among Adolescents: A Pre-Test/Post-Test Study

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ABSTRACT

Background: Bullying is widespread in schools, yet most adolescents who witness it do not intervene. Fear, pressure from peers and not knowing what to do are common reasons for remaining silent. We examined whether a short school-based program built on two Dialectical Behavior Therapy (DBT) modules, mindfulness and interpersonal effectiveness, could shift adolescents' behavior around bullying.

Methods: This single-group quasi-experimental study used a pre-test/post-test design. Fifty adolescents aged 13–18 years were recruited from a school through purposive sampling. The program consisted of a baseline session, two skills sessions (core mindfulness; DEAR MAN, GIVE and FAST strategies practiced through role-play) and a final evaluation session, spaced 3–5 days apart. Bystander Behavior, Victim Response Behavior and Bullying Perpetration Behavior were assessed with the Behavior Toward Bullying Scale (BTBS) at baseline and after the program. Analysis used paired-samples t-tests, with Cohen's dz as the effect size.

Results: Scores on Bystander Behavior dropped from 18.70 ± 3.42 to 16.46 ± 1.98 ($p < .001$, $dz = 0.53$), and scores on Victim Response Behavior from 18.60 ± 2.50 to 16.24 ± 2.33 ($p < .001$, $dz = 0.62$); on this scale, lower scores mean more adaptive responses. There was no significant change in Bullying Perpetration Behavior ($p = .148$, $dz = 0.21$).

Conclusion: After a brief DBT-informed program, adolescents showed moderate short-term improvement in how they responded to bullying, both as bystanders and as targets. Firm conclusions will require controlled trials with longer follow-up and behavioral outcome measures.

Keywords: *Adolescent; Bullying; Dialectical Behavior Therapy; Helping Behavior; Mindfulness*

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INTRODUCTION

Bullying refers to deliberate, repeated aggression toward a person who cannot easily defend themselves, and it ranks among the most frequent forms of peer aggression during adolescence. According to Global School-based Student Health Survey data from 29 countries, an average of 39.4% of students aged 12–15 years had been victimized[1]. Its consequences extend well beyond the school environment. In a pooled analysis of 16 studies involving over 34,000 students, those who were bullied were approximately 1.7 times as likely to report suicidal ideation as their peers[2]. Longitudinal meta-analytic evidence shows that involvement in school violence, in any role, predicts poorer mental health and lower academic achievement later on, even when prior functioning is controlled for[3]. National survey data tell a similar story about schooling: children who are bullied are more likely to repeat a grade, to be absent for 11 days or more, and to feel disconnected from school[4].

A similar pattern has been reported in Pakistan. When 358 university students in Peshawar were surveyed recently, around two-thirds said they had been bullied at least once, usually verbally, and those affected reported anger, sadness, loneliness and withdrawal from others[5]. Weak social support networks and a shortage of school-based prevention have been highlighted as problems across developing regions[6], and in Pakistani schools, structured anti-bullying programs that teach specific skills are still rare.

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Bullying rarely takes place in private between two students. Peers are usually present, and their reaction strongly influences whether the bullying continues or stops[7]. Yet classmates typically name only one student in every five or six as likely to stand up for a victim[8]. Many young people keep silent out of fear of being targeted next, uncertainty about how to respond, or concern for their own social position[8]. Two factors increase the likelihood of defending. In a study of 672 adolescents, self-efficacy for defending predicted actual defending in cyberbullying situations, partly through a stronger intention to help, and empathy strengthened both of these links[9]. Similarly, in a Swedish cohort, defender self-efficacy predicted more defending and less passive bystanding one year on[10]. Since empathy and self-efficacy can both change, the skills that underpin defending can potentially be taught.

The decision to intervene is made within seconds, frequently in a state of high emotion. Mindfulness, the practice of paying attention to the present moment on purpose and without judgment, may let a student register fear or social pressure without acting on it, creating space to choose a response instead of freezing or joining in. In a sample of 429 adolescents, trait mindfulness was linked to defending, pro-bullying and passive bystander behavior[11], and longitudinal data show that it weakened the impact of cyberbullying victimization on depression and self-esteem[12]. Problems with emotion regulation also explain a meaningful proportion of the variance in cyberbullying perpetration[13]. On the other hand, universal school mindfulness programs offered as stand-alone interventions have had small or no effects in adolescents[14–16]. Attention training alone may be insufficient; adolescents are also likely to need practical interpersonal skills to act on what they notice.

Dialectical Behavior Therapy (DBT), created by Linehan, pairs acceptance-based mindfulness with behavioral skills training organized into four modules: mindfulness, interpersonal effectiveness, emotion regulation and distress tolerance[17]. DBT for adolescents is among the few treatments that have reduced self-harm and suicidal ideation in trials conducted by more than one research team[18], and school-based adaptations have been evaluated too. One Spanish trial of a DBT skills program found improvements in peer problems and prosocial behavior[19], while a large universal DBT-based program in Australia produced null and, in some cases, adverse short-term effects[20]. Such inconsistent results suggest that focused, carefully adapted content is preferable to transplanting the whole clinical program into schools. Two modules match the bystander problem particularly well. Mindfulness helps young people become aware of what is going on both inside them and around them, and interpersonal effectiveness, through DEAR MAN, GIVE and FAST, gives them the language to speak up assertively without damaging relationships or their self-respect. For this reason, our program was limited to these two modules.

Anti-bullying programs tend to work better when they engage peers informally and work directly with victims[21]. Programs targeted at bystanders have an overall effect size of d = 0.25, and knowledge, self-efficacy and coping skills appear to be their active components[22]. Even so, DBT-based skills have rarely been tested as a way to strengthen bystander behavior, and we could not find any such study from Pakistan. We therefore assessed the effect of brief DBT-based training in mindfulness and interpersonal effectiveness on adolescents' Bystander Behavior, Victim Response Behavior and Bullying Perpetration Behavior. Our hypothesis was that the first two would improve significantly after the program, while perpetration would change less.

METHODOLOGY

Study Design and Setting

We used a quasi-experimental single-group design with a pre-test and post-test to compare participants' responses before and after the intervention. Data were collected in January–February 2026 at Manzil Educational Organisation, House No. A-48/1, Street 14, Gulshan-e-Faisal, Bath Island, Karachi, Pakistan. Sessions were held in a classroom during the school day, at times agreed with the administration to avoid disrupting lessons.

Participants and Sampling

The study population consisted of adolescents aged 13–18 years attending school or college. Fifty volunteers were chosen by purposive sampling. For a two-tailed paired-samples t-test with a medium effect ($d_z = 0.5$), $\alpha = 0.05$ and power = 0.80, at least 34 participants are required; with 50 participants, the study exceeded this number and had a margin for dropouts.

Inclusion Criteria

- Adolescents aged 13–18 years.
- Enrolled in a school or college at the time of the study.

- Able to read, understand and respond to the questionnaire.
- Willing to attend all sessions, with written assent from the student and consent from a parent or guardian.

Exclusion Criteria

- Adolescents currently receiving treatment for a severe psychological disorder.
- Previous training in DBT or in any structured mindfulness program.
- Missing any of the intervention sessions.

Operational Definitions

Mindfulness

Deliberate, non-judgmental awareness of one's thoughts, feelings and bodily sensations in the present moment, taught in this study through DBT core mindfulness skills.

Interpersonal effectiveness

The capacity to ask for what one needs, say no to unreasonable demands, preserve relationships and keep one's self-respect in situations of social conflict, taught using the DEAR MAN, GIVE and FAST strategies.

Bystander intervention

An adolescent's confidence and readiness to act effectively on witnessing bullying, assessed with the Bystander Behavior subscale of the BTBS.

Victim response behavior

The way an adolescent reacts when bullied, ranging from assertive to avoidant or retaliatory responses, assessed with the matching BTBS subscale.

Bullying perpetration behavior

Self-reported tendency to start or take part in bullying others, assessed with the matching BTBS subscale.

Instruments

Demographic Proforma

A brief proforma collected information on age, gender, level of education, past exposure to bullying and the form of bullying experienced or observed (verbal, physical, relational/social or cyber).

Behavior Toward Bullying Scale (BTBS)

The researchers developed the Behavior Toward Bullying Scale (BTBS) on the basis of existing literature and conceptual frameworks of adolescent bullying behavior, drawing on earlier published measures such as the Bullying-Behaviour Scale of Austin and Joseph[23]. It aims to capture how adolescents tend to behave when they observe, experience or take part in bullying, across three dimensions: Bystander Behavior, Victim Response Behavior and Bullying Perpetration Behavior. Each subscale has six items, giving 18 items overall, presented in the structured-alternative format used by Austin and Joseph[23]. Respondents first decide which of two opposing statements describes them better and then rate it as "really true" or "sort of true" for them. Items are scored 1 to 4 and keyed so that a higher score means less adaptive responding; summing the items yields subscale scores between 6 and 24. A lower score therefore reflects more adaptive behavior, that is, more active and constructive helping as a bystander, more assertive and help-seeking reactions when targeted, and less participation in bullying others. We analyzed the subscales separately and did not compute a total score. Experts reviewed the items for content validity before data collection, and internal consistency was checked in this sample, with Cronbach's α between 0.80 and 0.90 for the three subscales, indicating good reliability.

Intervention Materials

The intervention was based on Linehan's *DBT Skills Training Manual* (2nd edition), using only the mindfulness and interpersonal effectiveness modules to match the aims of the program. We developed three supporting materials:

- ***Session guidebook:*** A step-by-step plan for every session, including exercises in breath awareness, body grounding and present-moment attention, simplified DEAR MAN, GIVE and FAST scripts, and role-play scenarios about bullying in school.
- ***Reflective activity worksheets:*** Prompts asking students to recognize their triggers, observe their emotional reactions and think through other ways of responding to bullying they had faced or seen.
- ***Homework sheets:*** Logs for daily mindfulness practice and for recording attempts to communicate assertively in everyday interactions.

Intervention

Table 1 outlines the four contacts that made up the program. A gap of 3–5 days between sessions allowed students to do their homework in between. Sessions ran for 30–45 minutes with groups of 4–5 students and were led by the principal investigator, a consultant clinical psychologist. The conceptual framework connecting the two DBT modules with the study outcomes is presented in (Figure 1)

Table 1. Session plan of the DBT-based mindfulness and interpersonal effectiveness program

Session	DBT focus	Content and activities	Homework
Baseline	Orientation and pre-test	Introduction to study aims; consent and assent; demographic proforma; BTBS pre-test; brief overview of bullying, mindfulness and DBT	None
Session 1	Core mindfulness	Psychoeducation on bullying, bystander roles and emotional reactivity (fear, anxiety, peer pressure); breathing awareness, body grounding and present-moment attention; observing thoughts and emotions without immediate reaction	Mindfulness reflection worksheet; daily breathing and grounding practice
Session 2	Interpersonal effectiveness	Simplified DEAR MAN, GIVE and FAST skills; structured role-plays of bullying and bystander scenarios; guided group discussion and feedback	Practice assertive communication in real interactions; record attempts on reflective activity sheet
Session 3	Evaluation and consolidation	BTBS post-test (administered first); group reflection on confidence and bystander responses; review of key skills; closure	None

Note. BTBS = Behavior Toward Bullying Scale; DBT = Dialectical Behavior Therapy; DEAR MAN = Describe, Express, Assert, Reinforce, Stay Mindful, Appear confident, Negotiate; GIVE = Gentle, Interested, Validate, Easy manner; FAST = Fair, no Apologies, Stick to values, Truthful. Sessions were held 3–5 days apart.

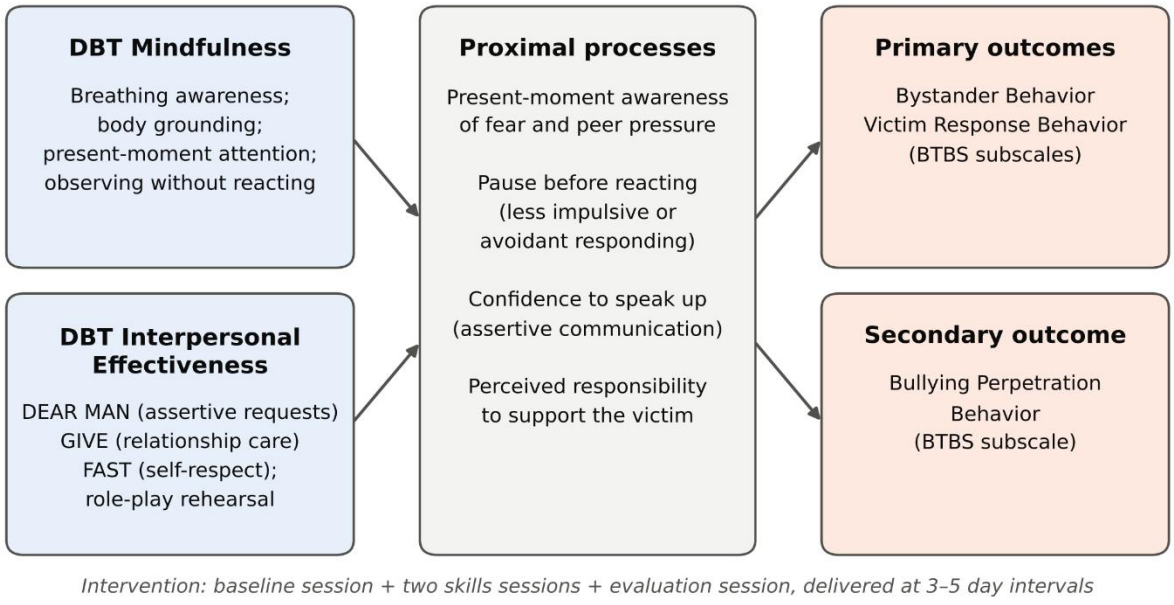


Figure 1. Conceptual framework showing how the two DBT skills modules are expected to influence the study outcomes through proximal processes.

Procedure

We first obtained permission from the school administration. Students were invited through classroom announcements and referrals from teachers and were screened for eligibility. Written information about the study was given to eligible students and their parents or guardians, and assent and consent were secured before the baseline session. At baseline, participants filled in the demographic proforma and the BTBS (pre-test), after which the two skills sessions took place. During the evaluation session, the BTBS was repeated (post-test) ahead of the group reflection, so that the discussion could not influence answers. All 50 participants attended all sessions and completed both assessments.

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Statistical Analysis

Analysis was performed in IBM SPSS Statistics (version 30). Frequencies and percentages were used for categorical variables, and means with standard deviations for continuous scores. The Shapiro–Wilk test, appropriate for samples of 50 or fewer, was used to check whether difference scores were normally distributed. Pre-test and post-test scores on each BTBS subscale were compared with paired-samples t-tests. We report mean differences with 95% confidence intervals (CIs) and effect sizes as Cohen's dz ($t/\sqrt{n}$), with 0.2, 0.5 and 0.8 taken as small, medium and large. A two-tailed $p < .05$ was considered significant.

Ethical Considerations

The Foundation of Medical Research and Laboratories (FMRL) granted ethical approval (Reference No. FRML/2025/014). Parents or guardians gave written informed consent, and the adolescents gave written assent. Taking part was voluntary, students were free to withdraw at any point without penalty, and participant codes were used to keep all data anonymous. The study adhered to the Declaration of Helsinki. Any student who reported distress during the sessions was to be referred to the school counselor.

RESULTS

Participant Characteristics

The full sample of 50 adolescents completed the program and both assessments and was included in the analysis (Table 2). Slightly more than half were 16–18 years old (52.0%) and female (54.0%), and the majority were studying at high school or college level (58.0%). Prior exposure to bullying was reported by 68.0%. Verbal bullying was the most commonly experienced or witnessed form (40.0%), with physical (22.0%), relational/social (20.0%) and cyberbullying (18.0%) less frequent.

Table 2. Demographic characteristics of participants (n = 50)

Variable	Category	n	%
Age group	13–15 years	24	48.0
	16–18 years	26	52.0
Gender	Male	23	46.0
	Female	27	54.0
Educational level	Middle school	21	42.0
	High school/college	29	58.0
Previous exposure to bullying	Yes	34	68.0
	No	16	32.0
Type of bullying experienced or witnessed	Verbal	20	40.0
	Physical	11	22.0
	Relational/social	10	20.0
	Cyberbullying	9	18.0

Note. n = number of participants; % = percentage of the total sample.

Pre-Test and Post-Test Comparison

Results of the paired comparisons appear in Table 3. Mean Bystander Behavior scores fell from 18.70 ± 3.42 before the program to 16.46 ± 1.98 afterward, a decrease of 2.24 points (95% CI 1.04 to 3.44; $t(49) = 3.74$, $p < .001$) with a medium effect ($dz = 0.53$). The largest change was observed in Victim Response Behavior, which dropped from 18.60 ± 2.50 to 16.24 ± 2.33, a mean decrease of 2.36 points (95% CI 1.28 to 3.44; $t(49) = 4.38$, $p < .001$; $dz = 0.62$). Because lower BTBS scores reflect more adaptive responding, both decreases represent improvement.

Bullying Perpetration Behavior scores showed only a small decline, from 19.56 ± 2.12 to 18.92 ± 1.99. This 0.64-point reduction did not reach significance (95% CI −0.24 to 1.52; $t(49) = 1.47$, $p = .148$), and the effect was small ($dz = 0.21$). The variability of Bystander Behavior scores also decreased noticeably after the program (SD 3.42 to 1.98), which suggests more uniform responses among students. Pre-test and post-test means are plotted in (Figure 2), and (Figure 3) presents the mean changes with their 95% CIs.

Table 3. Pre-test and post-test comparison of BTBS subscale scores (n = 50)

Subscale	Pre-test M (SD)	Post-test M (SD)	MD	95% CI of MD	t(49)	p	Cohen's d_z
Bystander Behavior	18.70 (3.42)	16.46 (1.98)	2.24	1.04 to 3.44	3.74	< .001	0.53
Victim Response Behavior	18.60 (2.50)	16.24 (2.33)	2.36	1.28 to 3.44	4.38	< .001	0.62
Bullying Perpetration Behavior	19.56 (2.12)	18.92 (1.99)	0.64	−0.24 to 1.52	1.47	.148	0.21

Note. Paired-samples t-test. M = mean; SD = standard deviation; MD = mean difference (pre-test minus post-test); CI = confidence interval; $d_z = t/\sqrt{n}$. Lower BTBS scores indicate more adaptive responding.

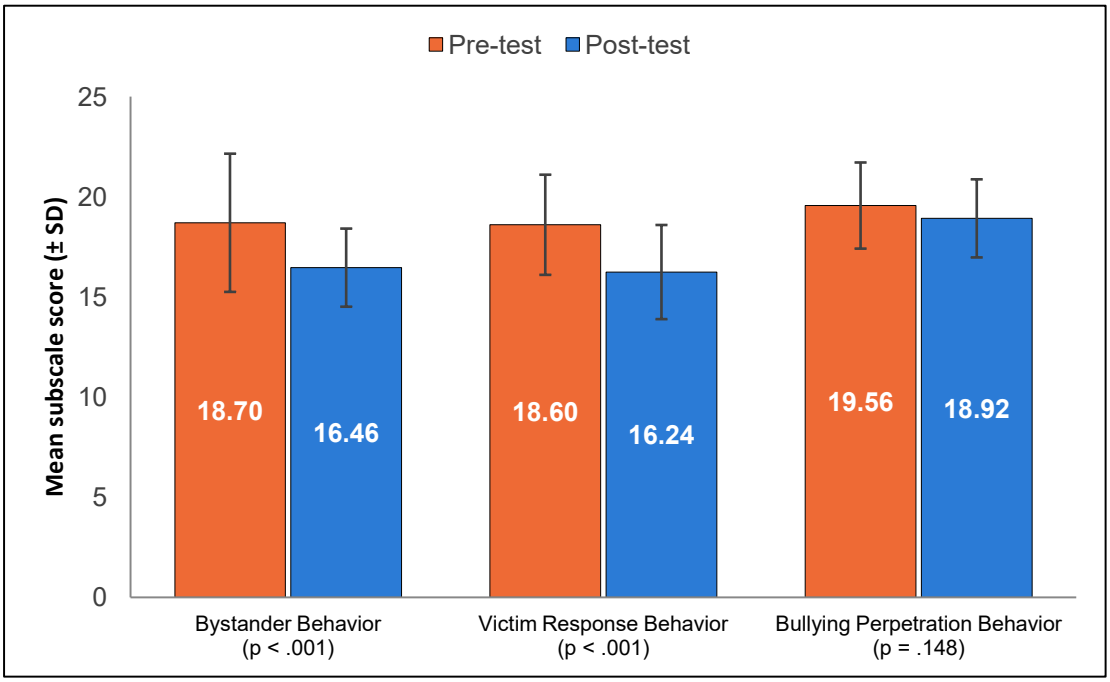


Figure 2. BTBS subscale scores (mean ± SD) before and after the program (n = 50). Lower scores reflect more adaptive responding

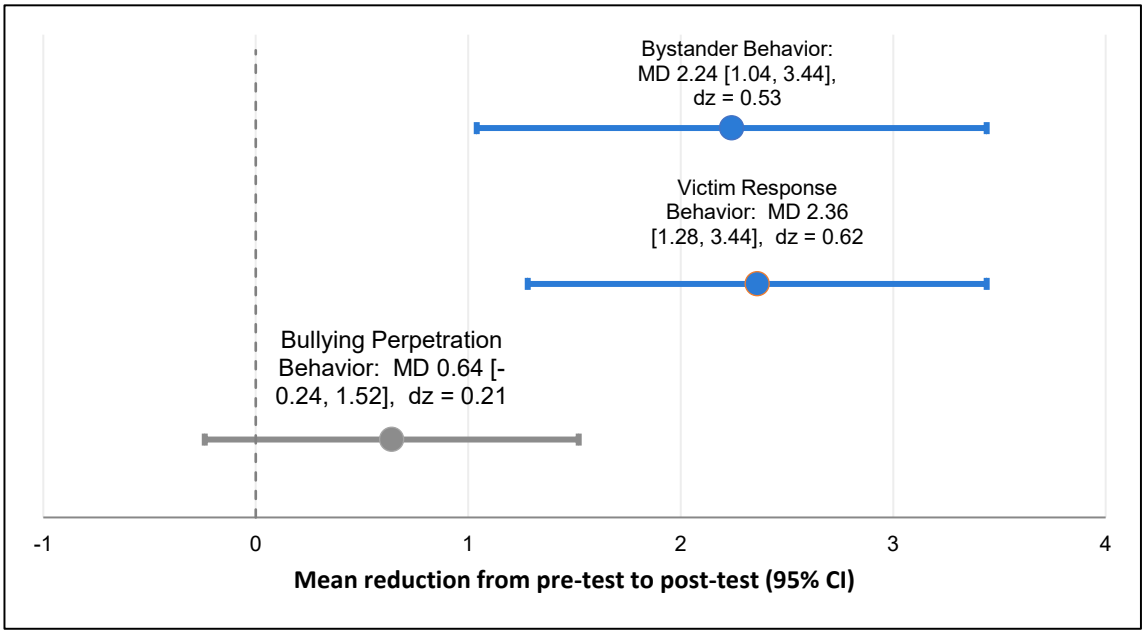


Figure 3. Mean decrease in each BTBS subscale with 95% confidence intervals and effect sizes (Cohen's dz). A change is significant when its interval does not include zero.

DISCUSSION

We examined whether a short program based on two DBT modules, mindfulness and interpersonal effectiveness, would alter adolescents' responses to bullying. After taking part, students reported significantly more adaptive behavior both as bystanders and when they were bullied themselves, with medium-sized effects. Self-reported perpetration, however, changed minimally. The hypothesis was therefore partly supported, and the pattern suggests that these modules mainly influence how students react to bullying rather than whether they join in.

The magnitude of these effects merits comment. For Bystander Behavior (dz = 0.53) and Victim Response Behavior (dz = 0.62), the effects exceed the pooled d of 0.25 that a recent meta-analysis reported for bystander-focused programs[22]. The same meta-analysis noted larger effects for programs shorter than one month and for samples under 100, both of which describe our study. Uncontrolled pre–post studies are known to inflate effect sizes, however, so the present estimates should be regarded as upper-bound values. Another observation is the reduced spread in Bystander Behavior scores after training. This may indicate that the students with the least adaptive responses at the start improved most, but individual-level analysis would be required to show this.

The gain in Bystander Behavior is consistent with the logic of the program. Through mindfulness, students learn to notice growing fear or group pressure without being controlled by it, and this brief pause may determine whether a student freezes or acts. Malin and Gumpel reported a link between trait mindfulness and both defending and passive bystanding in adolescents[11], lending support to this route. Interpersonal effectiveness supports the subsequent step. DEAR MAN, for instance, provides a structured framework for asking a bully to stop or for approaching a teacher. Practicing these scripts through role-play is likely to enhance defender self-efficacy, a predictor of future defending[9,10], and the perspective-taking in GIVE draws on the same empathy that helps convert the wish to help into action[9]. Practice with peers is also one of the program features most closely associated with reduced bullying[21].

Victim Response Behavior showed the greatest improvement. Bullied students frequently either withdraw or retaliate, and either reaction can perpetuate the cycle. The program offered an alternative: remaining calm enough to respond assertively and to look for help. Mindfulness has been found to soften the association between cyberbullying victimization and both depression and low self-esteem[12], and a school DBT program in Spain led to fewer peer problems and more prosocial behavior[19]. Our findings are in line with this work. They are particularly relevant in Pakistan, where being bullied has been linked to anger, low self-esteem and social withdrawal[5], and where schools often offer little formal support to victims[6].

The absence of change in perpetration was expected. Bullying others is sustained by status goals, peer reinforcement and moral disengagement[7,10], and a two-session skills program does not address any of these directly. Emotion regulation, the module we did not include, may be more relevant to perpetration, as difficulty regulating emotions accounts for a meaningful share of the variance in cyberbullying perpetration[13]. It is also possible that few of our participants were actively bullying others, which would leave limited scope for change on this subscale.

These encouraging results must be set against the broader evidence base. Large trials of universal mindfulness in schools have shown no sustained benefit for adolescents[16], reanalyses indicate that this age group gains particularly little[14,15], and a universal DBT-based program in Australia had some adverse effects in the short term[20]. Unlike those programs, ours was brief, focused closely on a single concrete social problem and centered on rehearsing specific responses. Whether this focus is what made the difference can only be established through controlled replication.

Bullying is also shaped by its wider context, and several factors influencing who is bullied and who intervenes were beyond the scope of this study. In Global School-based Student Health Survey data from 16 countries, those with more poverty and lower per capita income had higher rates of victimization, especially verbal victimization[24].

Children with disabilities are about twice as likely to experience violence[25], and across 135 studies, young people with neurodevelopmental or psychiatric conditions had almost three times the odds of being bullied[26]. Students who are perceived as different in any of these respects may respond to the program differently and may take on more social risk by intervening. Because we

collected only age, gender, education level and prior exposure, and did not adjust for these broader characteristics, the benefits may not be shared equally across subgroups.

Strengths

As far as we know, this is one of the first Pakistani studies to use DBT skills to target bystander behavior. Restricting the program to two modules kept its content clear and easy to replicate.

Sessions followed a written guidebook with standardized worksheets and homework, there were no dropouts, and we report effect sizes and confidence intervals in addition to p-values. The program also fitted within the school timetable, which supports its feasibility.

Limitations

Some limitations need to be considered. First, in the absence of a control group, the changes cannot be confidently attributed to the program, since maturation, repeated testing and regression to the mean could all have played a part. Second, the post-test was given soon after the final session, and we did not record whether participants saw or experienced bullying during the study. If they had no opportunity to use the skills, the lower scores may reflect changes in attitudes and intentions (a cognitive shift) rather than in actual behavior. Third, every outcome was self-reported, and students may have answered in ways they thought the facilitators would like, especially after a brief and friendly program; we did not measure social desirability. Fourth, purposive sampling at a single site restricts generalizability. Fifth, potential confounders, including socioeconomic status, academic performance, disability and differences in appearance, were neither measured nor controlled. Sixth, the BTBS was designed for this study and, beyond expert review and internal consistency in this sample, has not been validated in an independent sample. Finally, the dose was low, and the emotion regulation and distress tolerance modules were left out.

Recommendations

Future research should adopt a cluster randomized design with a waitlist or active control group and should follow participants for at least three to six months. Asking students to keep weekly logs of bullying they witness or experience, and the skills they use in each case, would help distinguish real behavior change from a change in thinking, and adding teacher reports or peer nominations would lessen dependence on self-report. A short social desirability scale should be administered with the outcome measure. Gender, socioeconomic status, academic performance, disability and other markers of difference should be recorded and entered as covariates or moderators. Changing perpetration may require longer programs that include the emotion regulation module. In schools, the gains might be maintained by training teachers to reinforce DEAR MAN and mindfulness during everyday routines and by providing culturally adapted materials in Urdu.

CONCLUSION

Taking part in a brief school-based program built on DBT mindfulness and interpersonal effectiveness skills was associated with medium short-term improvements in adolescents' bystander behavior and in their responses to being bullied, while self-reported perpetration remained largely unchanged. Being brief, structured and easy to incorporate into the school timetable, the program is a realistic option for anti-bullying work in Pakistani schools. As there was no control group, outcomes were self-reported and outcomes were measured immediately after the program, these results should be considered preliminary. Controlled trials with longer follow-up, behavioral outcome measures and attention to confounders are needed to establish whether these early improvements lead to genuine changes in how adolescents behave when bullying occurs.

Author Contributions

SJ: Conception and design, data collection, and manuscript writing.
SF: Methodology, data collection, and critical review of the manuscript.
SA: Data collection, manuscript writing, and critical revision of the manuscript.
RS: Data collection and literature search.
SSK: Data interpretation, manuscript editing, and final approval of the manuscript.

Conflict of interest: The authors declare no conflict of interest.

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Ethical approval: Approved by the Foundation of Medical Research and Laboratories, Karachi (Reference No. FRML/2025/014).

Data availability: The de-identified dataset is available from the corresponding author on reasonable request.

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