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Dialectical Behavior Therapy Skills for Families of Individuals With Behavioral Disorders: Initial Feasibility and Outcomes

Chelsey R. Wilks and Helen Valenstein-Mah, *University of Washington*
Han Tran, *University of Memphis*
Alexandra M.M. King, *University of Nevada Reno*
Anita Lungu and Marsha M. Linehan, *University of Washington*

Family members of individuals with behavioral disorders are a valuable source of logistical and emotional support for patients. Family members may take on tremendous financial and/or psychological responsibility to care for their loved ones, which can result in poor psychological outcomes for the family and, in turn, impede the recovery of the patient. Dialectical Behavior Therapy (DBT) skills training is an effective treatment that has been utilized with numerous populations, including family members of individuals with behavioral problems, and has shown efficacy in improving various interpersonal outcomes; however, no study has examined feasibility and outcomes of delivering all four unabridged DBT skills modules to this population. Twenty participants attended weekly DBT skills classes for 6 months, where they acquired skills in mindfulness, emotion regulation, interpersonal effectiveness, and distress tolerance. There were significant pre-post improvements for emotion dysregulation, stress reactivity, and various interpersonal outcomes; there were no significant changes in depression or anxiety. These results suggest that DBT skills may be effective at improving broad clinical domains in a sample of family members of individuals with behavioral problems. This research is the first step in demonstrating that DBT skills might benefit family members of patients with heterogeneous mental health problems and, therefore, fits in to the field's growing interest in cost-effective transdiagnostic interventions.

Family members of individuals with behavioral disorders are often one of the most important sources of support for these individuals. Such support can be emotional (e.g., offering empathy, cheerleading), logistical (e.g., providing transportation to treatment, housing), as well as financial (e.g., covering day-to-day costs of living, medical expenses), and can depend on the course or severity of the disorder (Clark, 1994; Papastavrou, Charalambous, Tsangari, & Karayiannis, 2012; Schulz & Martire, 2004;). Behavioral disorders in this context refers to individuals with mental health problems such as depression, anxiety, and/or personality disorders. Mental disorders are more common among unemployed individuals, and as many as 50% of adults with severe behavioral disorders are living with family members (Fryers, Melzer, & Jenkins, 2003; Marshall & Solomon, 2004). Informal caretaking, often done by the patient's family, is prevalent, yielding approximately 52 million caregivers of individuals with physical or mental illnesses or disabilities in the United States alone (Health and Human Services, 1998). As a result, family members often take on tremendous financial and emotional responsibility when caring for their loved ones.

Family members can experience increased anxiety and depression as a direct result of caring and providing resources for their loved ones. Benazon and Coyne (2000) found that spouses of depressed individuals experience increased depression that is attributable to their caretaking responsibilities. Likewise, in a systematic review of family members of individuals with eating disorders, family members were consistently found to have high levels of emotional and psychological distress, including diminished concentration and sleep loss due to worry (Zabala, Macdonald, & Treasure, 2009). Finally, family members often experience increased shame, guilt, and self-blame related to their loved-one's disorder (Muhlbauer, 2002; Phelan et al., 1998). In turn, the strain from caring for a family member with behavioral disorders can have deleterious effects on the recovery of the patient; for example, research has documented that interpersonal burden of the informal caretaker role contributed to slower patient recovery (Cole & Reiss, 1993). Taken together, the stress related to caring for individuals with behavioral disorders

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can be extensive, with detrimental consequences for both the family member and patient.

Dialectical behavior therapy (DBT; Linehan, 1993, 2014) is a modular, transdiagnostic treatment with a strong evidence base for improving emotion dysregulation, interpersonal problems, and dysfunctional behaviors (see Linehan & Wilks, 2015). Standard DBT is an intensive, year-long program consisting of weekly 1-hour individual therapy sessions, weekly skills training group, 24-hour access to phone coaching, and weekly consultation group for the therapist. More recently, DBT skills training as a standalone treatment has also shown to be effective in treating numerous clinical populations, with individuals experiencing reductions in emotion dysregulation, depression, and improving general functioning, among other outcomes (for a review, see Valentine et al., 2014). Further, DBT skills use has been identified as a mediator for treatment targets (e.g., interpersonal problems, suicidal behavior; Neacsiu, Rizvi, & Linehan, 2010).

The DBT skills component includes training in regulating emotions, tolerating distress, interpersonal effectiveness, and mindfulness, directly targeting effective management of one's own emotional experiences and teaching skills on how to improve relationships. Thus, the emphasis on both self- and other-focused behavioral skills may make DBT skills a particularly appropriate and potent intervention for family caregivers of individuals with behavioral problems who need tools to manage their own distress as well as their relationship with their family member. Specifically, DBT skills could improve the ability of family members to better regulate their own emotions, which may increase self-efficacy (Bandura, 1982) and level of control in handling stressful interpersonal situations with their family member with behavioral disorders. Furthermore, DBT includes distress tolerance skills focused specifically on navigating crisis situations in an effective way, which could be needed in potential crisis situations involving their behaviorally disordered family members. Integrated within the distress tolerance module is the skill of radical acceptance, which provides family members with a foundation to accept (or work toward accepting) their loved ones as they are in that moment. Additionally, training in interpersonal skills (such as assertiveness) may make family members more effective in negotiating demands and improving their relationships, which may reduce caregiver burden as a result. For instance, they may interact better with their relative or be more successful in asking for and receiving support from others in the family or community. Mindfulness skills may also help family members become more aware of their thoughts and emotions related to their distressed family member and help decrease reactive and ineffective emotions and behaviors.

A growing body of research has started to examine the impact of DBT skills training for family members of individuals with behavioral problems. Family Connections® (FC®) is an adaptation of DBT that provides psychoeducation, brief skills training, and support specifically designed for family members of individuals with borderline personality disorder (BPD) (Fruzzetti & Hoffman, 2004). FC is based on the standard DBT skills training curriculum, and there are also several points in which it departs from the standard training. First, in line with its explicit focus on family members of individuals with BPD, two of the six modules taught in FC are dedicated to describing the research on BPD and to providing psychoeducation on the development of BPD and other BPD-specific problems. Second, most of the skills practices in FC are focused on teaching family members how to best interact with their loved one who has a BPD diagnosis. In contrast, skills practice in standard DBT group aims to generalize skills practice to all areas of life where effective behavior and emotion regulation are needed. Finally, each FC skills training group is led by two volunteers, most of whom are former group participants (though some clinicians run FC groups as well). After a family member completes the program they can go through leader training, join with another leader, and create their own group (Hoffman & Fruzzetti, 2005). This system allows the FC program to be provided to families free of cost.

The FC curriculum has been examined with family members of individuals with BPD and suicide attempters. In these pilot trials, results revealed that family members reported significant reductions in grief, depression, perceived burden, and caregiver fatigue, as well as improved emotional well-being (Rajalin, Wickholm-Pethrus, Hursti, & Jokinen, 2009; Hoffman et al., 2005; Hoffman, Fruzzetti, & Buteau, 2007). While the research on FC outcomes is encouraging, the current intervention and data are specific to family members of individuals diagnosed with BPD. We believe the standard DBT skills training is applicable to family members of individuals with a larger variety of behavioral disorders than just BPD. Similarly, we believe there is more commonality than difference in the areas where family members of individuals with different behavioral disorders (not only BPD) need help, making the skills teachable within a heterogeneous group. Providing DBT skills training to family members of individuals with diverse behavioral problems has the potential benefit of making the intervention more cost-effective (as recruitment for groups would include a larger population) and disseminable on a larger scale.

To the best of our knowledge, no study has examined the feasibility and outcomes of delivering all four unabridged DBT skills modules to family members. Thus, this research aims to investigate the feasibility and preliminary outcomes