



Family Skills Training in Dialectical Behaviour Therapy: The Experience of the Significant Others



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ABSTRACT

Aim: The aim was to describe significant others' experiences of dialectical behaviour therapy- family skills training (DBT-FST), their life situation before and after DBT-FST, and measurement of their levels of anxiety and depressive symptoms.

Methods: The study had a descriptive mixed method design. Data were collected with free text questionnaires ($n = 44$), group interviews ($n = 53$) and the HAD scale ($n = 52$) and analysed by qualitative content analysis and descriptive and inferential statistics.

Results: The results show that life before DBT-FST was a struggle. DBT-FST gave hope for the future and provided strategies, helpful in daily life. For the subgroup without symptoms of anxiety and depression before DBT-FST, anxiety increased significantly. For the subgroup with symptoms of anxiety and depression the symptoms decreased significantly. This indicates, despite increased anxiety for one group, that DBT-FST is a beneficial intervention and most beneficial for those with the highest anxiety- and depressive symptoms.

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When a person suffers from psychiatric illness, significant others (SO) are affected in many ways. Studies show that SOs to persons with long-term psychiatric illness, regardless of the specific diagnose, suffer from psychological and emotional stress, experience powerlessness, shame, guilt and grief. The encounter with psychiatric care evokes feelings of being abandoned and alienated. (Ekdahl, Idvall, Samuelsson, & Perseius, 2011; Ewertzon, Lützen, Svensson, & Andershed, 2010; Östman, 2000; Sjöblom, 2010; Syrén, 2010).

Borderline personality disorder (BPD) is a severe psychiatric health problem. It is characterised by patterns of instability in affect regulation, impulse control, interpersonal relationships, lacking control of aggressive impulses, serious dissociative symptoms, and problems with self-image. Suicidal and deliberate self-harm behaviour is also characteristic (DSM-V, 2013). Approximately 60–70 % of treated BPD patients attempt suicide, and 5–10 % commit suicide (APA, 2001; Lieb, Zanarini, Schmahl, Linehan, & Bohus, 2004; Paris, 2002). Previous studies point toward extremely low health-related quality of life in this group, and the persons themselves describe daily struggle with extreme suffering, bad self-confidence and self-hate (Perseius, Ekdahl, Åsberg, & Samuelsson, 2005; Perseius, Andersson, Åsberg, & Samuelsson, 2006). They tend to evoke stress, uneasiness

and attitudes of being troublesome among the staff involved in the treatment (Bland & Rossen, 2005; Commons Treloar & Lewis, 2008). In Sweden, persons under the age of 18 are not diagnosed with personality disorder diagnoses. The personality is formed during adolescence, the normality issue depends on development, and the expected behavior, cognitive ability and emotional reactions are all related to age. The lack of stability and maturity in adolescence are important reasons why personality disorder diagnoses are not normally used until the person reaches the age of 18 (Svensk Psykiatri, 2006).

SOs to persons with BPD show higher levels of psychological distress compared to the general population, and they often have limited knowledge about the disorder (Hoffman, Buteau, Fruzzetti, & Bruce, 2003; Scheirs & Bok, 2007). Being an SO to a person with BPD symptoms has been described as “a life tiptoeing” (Ekdahl et al., 2011). The SOs' ability to handle everyday life, and their ability to create a non-stressful home environment have shown to be successful strategies for the recovery of persons with psychiatric illness. In order to do that the SOs need to develop constructive coping strategies. Support to SOs has therefore been recognized as an important area for development in psychiatric care (Hoffman, Fruzzetti, & Buteau, 2007; Orhagen, 1992).

FAMILY SKILLS TRAINING IN DIALECTICAL BEHAVIOUR THERAPY

Dialectical behaviour therapy (DBT) is a form of cognitive behavioural therapy, which is developed especially for persons with

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BPD who have a suicidal and self-harming behaviour (Linehan, 1993). Randomized controlled trials on the effects of DBT show very encouraging results on a range of variables, such as; suicide attempts, acts of deliberate self-harm, treatment drop out and inpatient days in psychiatric care (Linehan, Armstrong, Suarez, Allmon, & Head, 1991, 1994; Linehan, Tutek, Heard, & Armstrong, 1994; Linehan, Heard, & Armstrong, 1993; Van Den Bosch, Koeter, Stijnen, Verheul, & Van Den Brink, 2005). In a qualitative study the patients have described the therapy as life saving (Perseius, Öjehagen, Ekdahl, Åsberg, & Samuelsson, 2003). In Sweden DBT is offered in some psychiatric units to persons under the age of 18, even though they are not diagnosed with BPD. The teenagers suffer from self-harming behaviour and show BPD-symptoms.

Dialectical behaviour therapy- family skills training (DBT-FST) is a family program built on the same principals as DBT. The program has four goals: 1) to educate family members on different aspects of BPD, 2) to teach family members communication style that create and maintain a mutually validating environment, 3) to help family members become less judgmental toward each other, and to accept the dialectical underpinnings of DBT i.e. there is neither “one truth” nor any “absolute” truth, and 4) to provide a safe forum where patients and family members can discuss issues like self-destructive behaviour, feelings of rejection, anger, sadness, and suicide thoughts. In order to reach these goals, the participants learn five DBT-skills; 1) interpersonal effectiveness, 2) mindfulness skills, 3) emotion regulation, 4) distress tolerance, and 5) validation (Hoffman, Fruzzetti, & Swenson, 1999).

Studies on DBT-FST in the United States show significant decrease in experienced sorrow and burden, improved well-being as well as significant increase in experiences of mastering the situation. However, significant differences regarding depressive symptoms have not been shown (Hoffman et al., 2005; Rajalin, Wickholm-Pethrus, Hursti, & Jokinen, 2009). The manual of DBT-FST was translated to Swedish in 2006, and since then the program has been used in a few Swedish psychiatric services that provides DBT. To our knowledge the present study represents the first attempt to describe experiences from DBT-FST with a combined qualitative – quantitative approach.

The aim of the present study was threefold: a) to describe SOs experiences of DBT-FST, b) to describe their life situation before and after DBT-FST, and c) to measure their levels of anxiety and depressive symptoms.

METHODS

The study had a descriptive mixed method design. The researchers collected and used both qualitative and quantitative data (Tashakkori & Teddlie, 2010).

Table 1
The Sampling Process.

	N = 70, Age 42–75	Participants (N = 70)	Men (n = 28)	Women (n = 42)
HAD, baseline	70		28	42
HAD, follow up.	52		21	31
Free forms	44		17	27
Group interviews	53 (10 grps with 4–8 p.)		21	32

Context of the Study and Participants

The study was conducted in a child- and adolescent psychiatry unit in a large Swedish city. During the 2-year project period, DBT was implemented as treatment for self-harming patients showing BPD symptoms. All adults with a parental relationship to children (aged 13–18) in DBT treatment under that period were offered to participate in DBT-FST. The adults, who accepted, participated in DBT-FST during the same period their children participated in DBT treatment. DBT-FST was carried out in groups with six to eight participants during a 2 1/2 hour session, once a week for 10 to 12 weeks. The sampling for the study was consecutive. All SOs participating in DBT-FST under the project period were invited to participate in the study. All of them consented (in total 70 persons). See Fig. 1 for overview of the sampling process.

Data Collection

Data were collected by a) an inventory measuring symptoms of anxiety and depression (Hospitals Anxiety and Depression Scale, HAD), b) an individual open question, free text answer questionnaire, and c) group interviews (see Table 1). The interviews took place in the premises of the psychiatric unit, lasted between 60–90 minutes, and were audio taped and transcribed. Ten groups with four to eight SOs in each group participated in the interviews. The first and the last author conducted all data collection.

Hospital Anxiety and Depression Scale (HAD)

HAD is a scale and measures levels of anxiety- and depression symptoms respectively, in two separate subscales. It contains 14 items with seven items relating to anxiety, and seven items to depression. The score on each of these subscales is the sum of individual item scores (range for each item 0–3, range for each subscale 0–21), with higher degree of anxiety and depression the higher the score (Zigmond & Snaith, 1983). In clinical settings the instrument is used for screening purposes. The cut-off for clinical relevant anxiety and depression is considered to be 8 points or higher (Bjelland et al., 2002).

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Figure



Fig. 1. Time axis regarding data collection.

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