

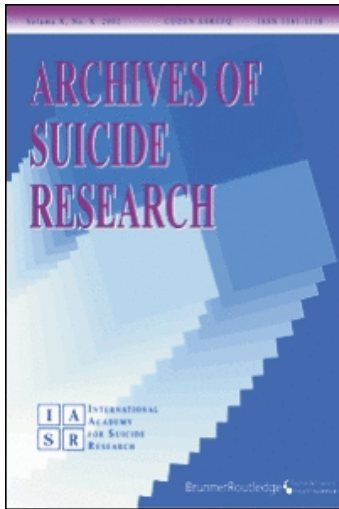
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Dialectical Behavior Therapy-Based Skills Training for Family Members of Suicide Attempters

Mia Rajalin, Lina Wickholm-Pethrus, Timo Hursti, and Jussi Jokinen

This pilot study evaluated the effect of Family Connections (FC), a Dialectical Behavior Therapy-based manualized skills training program, for family members of suicide attempters. The DBT-based skills training program aims to enhance the knowledge of wide range research based aspects of suicidal behavior and treatment recommendations. Furthermore it includes skills training for interpersonal relationships and also offers family members an opportunity to share their experiences. Thirteen participants completed the 9-week program with pre- and post self-report questionnaires. The results showed significant reduction in burden, improved psychic health and an increase in well-being regarding the relation with the patient. These results provide support for the need and importance of a DBT-based skills training program addressed specifically to family members of suicide attempters.

Keywords DBT-based skills training, Family Connections, family members, prevention, suicide attempt

INTRODUCTION

A suicide attempt is a challenge both for the patient and for family members. Thoughts concerning what could have been done to prevent the suicide attempt are common as well as feelings of guilt, powerlessness and hopelessness (Talseth, 2001). Family members of suicide victims have an increased risk for depression and anxiety (Pfeffer, Jiang, Kakuma et al., 2002; Van Dongen, 1991).

The suicide attempt is often communicated to the environment in some way (Beskow & Wasserman, 2002). Suicidal

communication is hard to uncover and healthcare professionals and family members should be able to recognize suicidal communication to prevent suicide. A recent study of suicide attempters suggested that their difficulties in interpersonal relationships affect family relations in particular (Jollant, Guillaume, Jausent et al., 2007). Furthermore family members of suicide attempters are not enough involved in the patient's treatment (Magne-Ingvar & Öjehagen, 1999).

There is strong scientific evidence that psychoeducation addressed to family members of schizophrenic patients has a

positive effect both for the patient and for the family member (McFarlane, 2003; Miklowitz & Hooley, 1998) and that the family members' emotional overengagement increases the risk for the patient to relapse (Hansson & Jarbin, 1997).

A study of family members of persons with borderline personality disorder (BPD) showed that uncertainty regarding the diagnosis and incorrect knowledge of the disorder may increase their burden and level of depression (Hoffman, Buteau, Hooley et al., 2003). When family members are involved in treatment there is a reduction in patient relapse, the recovery is facilitated and the wellbeing of the family members is heightened (Dixon, McFarlane, Lefley et al., 2001).

Family Connections (FC), (Fruzzetti & Hoffman, 2004), is a manualized skills training program directed to families with a member with BPD based on Marsha Linehan's dialectical behavior therapy (DBT). DBT and DBT-B (shorter version of DBT) have been shown to significantly reduce suicide attempts among women with BPD (Lynch, Chapman, Rosenthal et al., 2006; Stanley, Brodsky, Nelson et al., 2007). Studies of FC have shown promising results with a reduction of burden and an improved relation with the patient (Hoffman & Fruzzetti, 2007; Hoffman, Fruzzetti, Buteau et al., 2005; Hoffman, Fruzzetti, & Buteau, 2007).

Aim of the Study

The aim of the study was to evaluate the effect of a modified version of Family Connections (Fruzzetti & Hoffman, 2004). We hypothesized that the DBT-based skills training program addressed to family members of suicide attempters would have an effect on their wellbeing in general, on their level of depression and anxiety, experience of burden and experience of quality of life measured with the Brief Symptom Inventory, Beck

Depression Inventory, Burden Assessment Scale, Quality of Life Scale and Questions about Family Members.

METHOD

Participants

The Regional Ethical Review Board in Stockholm did not find any objections to the study (Dnr 2006/40–31). Family members gave informed consent. The participants were family members of suicide attempters being treated at the Suicide Prevention Clinic at Karolinska University Hospital. Eighteen family members—10 women and 8 men—were randomized into two groups in an open trial. Mean age of participants was 44.8 (SD = 12.7). The relation to the patient in treatment was as follows; five were husbands or live-in partners, three were fathers, nine were mothers and one sister. Family members were not diagnosed according to DSM IV. Thirteen family members who completed the 9-week program with pre- and post measurements were included in the analysis. Their attendance rate was 79%.

Family Connections

The program is divided into six modules: psychoeducation, mindfulness, acceptance, emotion, validation and problem management (Fruzzetti, Shenk, Mosco et al., 2003; Fruzzetti & Hoffman, 2004; Linehan, 1993a, 1993b) and aims to:

- Increase the knowledge of symptoms, behaviors and treatment of the patient.
- Help the family member to better understand and handle his or her own emotions in relation to the patient.
- Induce the family member's sense of control and lower his or her stress level by implementing more effective communication and problem solving strategies.

- Enhance the family member's psychic health and wellbeing.
- Support the creation of a network for family members in similar situations.

Intervention

The DBT-based skills training program was given during 9 weeks with one weekly session. The first session comprised 4 hours while the other eight were 2 hours each. The groups were conducted by CBT-therapists trained in FC by Alan Fruzzetti, Associate Professor at University of Nevada, who gave permission to modify the program. The goal was to follow the original FC-manual as closely as possible. The main adaptation in the psychoeducational part included utilizing the latest research based information on risk factors for suicide attempts and completed suicide as well as information on psychiatric disorders with high suicide risk (mood disorders, personality disorders and substance abuse disorders). A clinical psychiatrist gave information about recommended treatment options. Information on the family members' follow-up treatment plan and how to reduce the risk at home were included.

Schedule

Session I: Introduction and psycho-education.

Session II: Presentation of the individual cases and introduction of mindfulness and validation. The purpose of mindfulness is to be able to accept experiences without attempting to change or avoid them. Validation means to confirm that somebody is true, comprehensible and logic seen from their point of view.

Session III: Information of modern theories of emotion (communicatory aspects of primary and secondary emotions, relationship between cognitions, emotions

and behaviors). Examples of difficult situations that family members encountered in connection to the suicide attempt were demonstrated in chain analysis.

Session IV: Acceptance. Identification of goals and values regarding the relationship with the suicide attempter.

Session V, VI, VII: Validation.

Session VIII: Problem management.

Session IX: Retrospect and outlook.

Instruments

The Beck Depression Inventory (Beck, Steer, & Garbin, 1998) was used to assess the level of depression, and Burden Assessment Scale (Reinhard, Gubman, Horwitz et al., 1994) to assess levels of objective and subjective burden. The Questions About Family Members (Hansson & Jarbin, 1997) is a scale that includes variables like criticism, hostility and emotional over involvement. The quality of life was assessed with Quality of Life Inventory (Frisch, Cornell, Villanueva et al., 1992). Finally, Brief Symptom Inventory (Derogatis, 1994) was chosen to measure the subjective experience of emotional discomfort.

Statistical Analysis

Wilcoxon Signed Ranks test for matched pairs was used to compare the data from pre- and post-test. Where data were normally distributed, paired samples t-test, was used to assess change from pre- to post-test. All tests were two-tailed (SPSS 14.0, 2005). The alpha value was set at $p < .05$.

RESULTS

The analyses were conducted on the data from the 13 participants who completed both the pre- and post-measurements.

General Psychiatric Health, Level
of Depression and Anxiety

Brief Symptom Inventory (BSI). The three global indexes in BSI investigate the general psychiatric health of the participants, the number of symptoms noticed and the intensity of these symptoms. The analysis showed a significant difference in the global index PSDI ($r = .52, p < .008$). Both GSI and PST showed a trend to a significant reduction between the two measures ($r = .36, p < .064$; $r = .34, p < .086$ respectively). An adherent intention was to investigate whether the level of anxiety changed between the two measures. The subscale in BSI that measures anxiety showed a significant difference between pre-test (Md = 0.67) and post-test (Md = 0.33), $T = 4, p < .05, r = .40$.

Beck Depression Inventory (BDI). There was a trend in reduction of depressive symptoms after completing FC, as shown in Table 1.

Experienced Level of Burden and
Quality of Life

Burden Assessment Scale (BAS). The difference between the pre- and posttest on BAS was statistically significant, $p < .01$, Table 1, and showed that the perceived

burden was reduced between the two measures.

The experienced quality of life was not changed on a significant level.

Wellbeing Regarding the Relation to the
Family Member

Questions about Family Members (QAFM). Table 2 shows the results from the analysis of the data from QAFM. Three out of four subscales, perceived criticism (PC), critical comments (CC), and emotional over involvement (EOI) showed significant differences between the measures. A decrease in perceived criticism from the family member, decreased criticism expressed by the participant towards the family member and less emotional over involvement was found. The result from the subscale perceived emotional involvement (PEI), was not significant.

Participants' Evaluation

The participants completed an evaluation form of the DBT-based skills training program. All participants stated that the program had led to positive changes in daily life and in relation to the patient in treatment. Almost everyone rated the psychoeducational part of the program highly, but the communication skills

TABLE 1. Mean (M), Standard Deviation (Sd), Median (Md), Interquartile Range (IQR), Degrees of Freedom (df), t-value (t), T-value (T), p-value (p), and Effect Size (Rosenthal's r) for BDI, BAS, and QOLI at Pre- and Posttest.

Scale	Pretest		Posttest		df	t	T	p	R
	M (Sd)	Md IQR	M (Sd)	Md IQR					
BDI		4.00 1.5–10.5		3.00 0.0–6.5			1	.059	0.37
BAS		12.00 11.0–23.5		7.00 5.5–21.5			2	.014	0.48
QOLI	2.46 (1.52)		2.70 (1.20)		12	-1.56		.146	0.41

TABLE 2. Mean (M), Standard Deviation (Sd), Degrees of Freedom (df), t-value (t), p-value (p), and Effect Size (Rosenthal's r) for QAFM's Four Subscales at Pre- and Posttest

Scale QAFM	Pretest M (Sd)	Posttest M (Sd)	df	t	p	R
PC (perceived criticism)	2.41 (0.53)	2.17 (0.44)	12	2.96	.012	0.65
PEI (perceived emotional involvement)	2.54 (0.64)	2.67 (0.61)	12	0.92	.375	0.28
CC (critical comments)	2.10 (0.33)	1.84 (0.37)	12	3.46	.005	0.71
EOI (emotional overinvolvement)	2.88 (0.44)	2.33 (0.57)	12	3.27	.007	0.69

trained seemed even more important. Participants further assessed mindfulness and chain analysis as effective tools in regulating emotion in difficult situations. Finally, the group setting itself, i.e., to share experiences and sense of loss with others in the same predicament, was invaluable to all group members.

DISCUSSION

In this study of family members of suicide attempters completing the DBT-based skills training program (FC) we found a significant reduction of experienced symptoms. The results show that the general wellbeing of family members has improved. Furthermore, their experience of burden has been reduced. Their wellbeing in the relationship to the suicide attempter has increased.

To our knowledge this is the first study of DBT-based manualized skills training program directed to family members of suicide attempters. The results are consistent with earlier results (Hoffman, Fruzzetti, Buteau et al., 2005; Hoffman, Fruzzetti, & Buteau, 2007) and indicate that it helps also family members of suicide attempters.

The general level of discomfort (GSI) was reduced after the intervention. The intensity in these symptoms (PSDI) was reduced while the number of symptoms (PST) decreased on a non-significant level. These changes might be explained by elements of acceptance and making life values and goals clear to the individual in the program. Even if the situation of

the family member remains unchanged, acceptance of reality facilitates looking upon his or her prospects with a more objective perspective.

The family members' level of anxiety was higher than normal at baseline (Fridell, Cesarec, Johansson et al., 2002). At post measurement it was lowered to a normal level (Fridell et al.). The program includes elements that explain the origin of anxiety and new coping strategies how to handle it which may explain this reduction in symptoms of anxiety.

At the beginning of the program the participants' level of depression was on a normal level according to Beck and associates (1988). Even so, there is a trend to a decrease of level of depression after completing the program.

The experience of burden among the participants was high in baseline measurement even in comparison with family members' ratings of burden in other studies (Ivarsson, Sidenvall, & Carlsson, 2004). This burden involved a worry of having negatively affected the suicide attempter's illness. Additionally, they were limited in their own activities. Post measurement shows that the experienced burden is significantly reduced. This finding is in line with the results of Hoffman et al. (2005, 2007). Family members are informed of the suicidal process and underlying factors with special focus on how to reduce risk at home. They learn new strategies on how to handle their emotional responses better and they meet others in the same

situation. These factors may contribute to this improvement.

The expressed criticism from both the patient and the family member decreased and the emotional overinvolvement was more balanced. Mindfulness, acceptance and validation may explain the change of dysfunctional patterns. Through the new knowledge and skills in handling problems within the family, the suicide attempter's way of functioning could be affected. This is in line with earlier research (Fruzzetti & Iverson, 2004; Lundblad & Hansson, 2005; Lynch, Chapman, Rosenthal et al., 2006) and plausible from a transactional point of view where one person's improvement is considered affecting the other's.

The results from this pilot study give preliminary support that the DBT-based skills training program has an effect on psychic health and wellbeing among family members of suicide attempters. Given that there was no control group in this first study the results should be interpreted with caution. However, it is an important first step to better help the families of suicide attempters.

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