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Dialectical Behavior Therapy - Family Skills Training

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Over the past three decades, family interventions have become important components of treatment for a number of psychiatric disorders. To date, however, there has been no family treatment designed specifically for borderline personality disorder patients and their relatives. This article describes one short-term family intervention called Dialectical Behavior Therapy-Family Skills Training. Based on Linehan's Dialectical Behavior Therapy (DBT), borderline patients' behavioral patterns are thought to result from a lifelong transaction between emotional vulnerability and invalidating features of the social and familial environment. Individual DBT focuses on reducing individual emotion dysregulation and vulnerability and enhancing individual stability. The complementary family interventions proposed in this article aim to: 1) provide all family members an understanding of borderline behavioral patterns in a clear, nonjudgmental way; 2) enhance the contributions of all family members to a mutually validating environment; and 3) address all family members' emotion regulation and interpersonal skills deficits.

Family therapy, in general, is a treatment that has gained prominence in the mental health field during the past 30 years. With its increase in popularity there have emerged not only different methods of family treatment (for example, structural family therapy) but also family treatments distinctly targeted for particular populations. Family therapies have been designed for use with relatives of patients with anorexia nervosa, alcohol abuse, as well as bipolar or unipolar disorder (see Beach, Sandeen, & O'Leary, 1990; Clarkin, Glick, Hass, et al., 1990; Miklowitz & Goldstein, 1990; Minuchin, Rosman, & Baker, 1978; Sisson & Azrin, 1986; Szmukler, Berkowitz, Eisler, et al., 1987). These family interventions increasingly reflect a more integrative approach that identifies not only the individual psychiatric disorder as relevant, but, equally important, the context in which the disorder exists.

One set of empirically evaluated family treatments conceived for a specific population are those developed for families of schizophrenic patients. These interventions include the psychoeducational approach designed by Anderson, Hogarty, and Reiss (1986), the family behavioral management developed by Falloon, Boyd, McGill, et al. (1985), and the multifamily groups of McFarlane (McFarlane, Link, Dushay, et al., 1995). These models have proliferated in popularity over the past 10 years, providing invaluable programs for relatives of schizophrenic patients. As a supplement to antipsychotic medication, evidence to date shows that family participation in these programs can reduce the rate of relapse for schizophrenic patients (see Hogarty, Anderson, Reiss, et al., 1986). Lam (1991) cites relapse rates of 6% to 23% in five studies at a 9-month to one-year posthospitalization period for family treatment (plus medication) versus 40% to 53% for control groups (medication only).

Another family intervention to note is that of Miklowitz and Goldstein (1997) who developed a family treatment specifically for bipolar patients and their relatives. Their 9-month outpatient treatment focuses on assisting families in understanding and becoming more effective in their relationships with their relative. Education, communication, and problem solving are at the core of the treatment, with skill modules specifically designed to target improvements in those areas. The goals of all the above family interventions are for family members to work together in partnership. The focus is to acquire much needed education on the particular disorder as well as to modify communication styles and behavioral patterns that affect both the family unit as a whole and, in particular, the individuals with specific disorders.

Borderline Personality Disorder

The diagnosis of borderline personality disorder (BPD) encompasses patients with a pervasive pattern of affective instability, severe difficulties in interpersonal relationships, problems with behavioral or impulse control (including suicidal behaviors), and disrupted cognitive processes (including problems of the self). More than 10% of all outpatients and as

many as 20% of all inpatients receive this diagnosis (Widiger & Frances, 1989), in addition to other concurrent Axis II and frequent Axis I diagnoses. Despite theoretical disagreements concerning the etiology (or etiologies) of BPD, research has found that these individuals were raised in families burdened by psychopathology and problematic interactions (see Bradley, 1979; Links, Steiner, & Huxley, 1988; Pope, Jonas, Hudson, et al., 1983; Shachnow, Clarkin, DiPalma, et al., 1997), as well as frequent physical and/or sexual abuse (Weaver & Clum, 1993; Zanarini, Gunderson, Mario, et al., 1989). In addition, there is evidence that maladaptive family communication patterns play a contributing role in both the etiology and maintenance of the disorder (Links, 1990).

The work presented in this article reflects the emerging success of a family intervention with BPD individuals and their relatives. The intervention is based on Dialectical Behavior Therapy (DBT). Although the intervention resembles other family approaches, there are several important distinctions. First and foremost, it is an intervention designed for BPD patients and their relatives. Second, it augments and reinforces the client's individual treatment since it teaches many of the same skills (in addition to others) taught in the individual therapy. DBT-FST in particular is viewed as an "additional" or "add-on" treatment to the individual work. Third, unlike with other psychiatric diagnoses (Anderson et al., 1986; Falloon et al., 1985; McFarlane et al., 1995; Miklowitz and Goldstein, 1997), a goal is not to lower the level of emotional overinvolvement (EOI)—a component ofthe expressed emotion (EE) construct—because certain aspects of EOI are viewed as positive for BPD clients (Hooley & Hoffman, 1999). Fourth, the "Consultation Hour" (where clients and relatives bring up family issues for consultation, with the goals of skill application/generalization and problem solving) is introduced early in the intervention, not as a final module (Miklowitz & Goldstein, 1997). Finally, the program was not created for posthospital discharge but, rather, for any point in the course of the disorder.

DIALECTICAL BEHAVIOR THERAPY

For the Individual Patient

Dialectical Behavior Therapy has been developed by Marsha Linehan over the past 2 decades. This comprehensive treatment in controlled trials, has been shown to be effective in reducing parasuicidal behaviors, inpatient hospitalization days, and anger, and in improving social adjustment (Linehan, Armstrong, Suarez, et al., 1991; Linehan, Heard, & Armstrong, 1993). The theory on which DBT is based is a transactional or dialectical model. The model is similar to other etiological models, that is, the diathesis-stress model, in that it recognizes the importance of both the individual and the environment in which he or she lives. The diathesis-stress model however, believes that certain characteristics of the individual *interact* with conditions in the environment. Linehan's biosocial model believes that the individual's behavior/functioning and the environment are continuously impacting and influencing each other. The two—the individual and the environment in combination—are *one* system and have *reciprocal influence*, thus creating a transactional rather than an interactional process. In addition, the transactional model (versus an interactional model that supports some kind of static state), focuses not only on reciprocal influence but also recognizes the continual flux of the individual-environment system.

DBT maintains that BPD is, at its core, a disorder of emotion dysregulation, resulting from the transactional process between a) the individual and b) the environment in which the individual was raised or presently lives. In short, individual dispositions to emotion vulnerability and dysregulation put demands on an already invalidating environment, and vice versa. Thus, these factors reciprocally influence each other, exacerbating both. The concept of the "invalidating environment," central to DBT, maintains that invalidation occurs when valid (true, effective, real) individual behaviors (especially private behaviors such as thoughts, self-concept, emotional and sensory experiences) are delegitimized, punished, criticized, or pathologized. A validating environment (or validation), on the other hand, confirms what another is thinking, feeling, or experiencing. What is particularly essential is that, as a behavior therapy, validation is determined by its function (reinforcement of skillful behaviors; accurate discrimination of emotions, and so on), and not by its form. That is, validation is not necessarily positive (it may involve acknowledging anger or grief), does not necessarily involve agreement with another, and is possible at multiple levels (see Linehan, 1997).

Individual DBT is a principle-driven, behavioral treatment (Linehan, 1993a,b) that typically includes weekly individual sessions, weekly group skills training, therapist consultation meetings, and some form of behavior generalization (such as brief telephone-skill coaching between sessions), all with the aim of replacing maladaptive behaviors with skillful, effective ones. The treatment is based on principles of dialectics, the biosocial model, a set of treatment strategies, and a clear hierarchy of treatment targets. The principaldialectic—change occurs in the context of acceptance of life as it is (Linehan, 1993a)—is the foundation of the treatment and central in every session. The treatment team helps to balance the therapist in her or his communication style, level of intervention (coaching the patient on doing for him/herself vs. intervening on behalf of the patient), and synthesis of acceptance (validation) versus change (behavioral analysis and problem solving).

The first phase of treatment in DBT is called Stage One. The targets in individual sessions are organized hierarchically as follows: 1) reduction of parasuicidal and life-threatening behaviors (including aggression toward others and neglect of

children); 2) reduction of treatment-interfering or treatment-destroying behaviors; 3) reduction of quality-of-life threatening behaviors; and 4) an increase in skills.

In the DBT model, BPD behavioral patterns are organized into five categories of dysregulation. These include: emotion dysregulation, interpersonal dysregulation, self dysregulation, behavioral dysregulation, and cognitive dysregulation. DBT is directed at all of these. Skill acquisition is central to the treatment and structured around four skill modules (1993b): 1) core mindfulness skills; 2) interpersonal effectiveness skills; 3) emotion regulations skills; and 4) distress tolerance skills.

DBT Adapted for the Family

Individual DBT has addressed the problems of the individual's emotional vulnerability (high sensitivity, high reactivity, slow return to baseline) component by intervening directly with the individual patient. Although interventions with family members are briefly noted in the original treatment manual, standard DBT does not directly attempt to affect the second component of the etiological model for BPD and related disorders, namely, that of the invalidating environment.

There are several levels of adapting DBT that are possible. First, one could simply apply DBT essentially intact to new populations (for example, to battering men; Fruzzetti, Rubio, & Thorp, 1998). Or, one could use the existing treatment to augment outcomes with borderline clients (like teaching the original DBT skills to family members or partners of borderline clients; Fruzzetti, Hoffman, & Linehan, in press). Finally, one could also develop new interventions (skill modules and/or treatment strategies), consistent with the transactional model, to intervene specifically at the level of the environment (say, a family or a residential center; Fruzzetti et al., in press). All three of these approaches have been initiated and are presently being evaluated.

For example, complementary DBT treatment modes (individual- and multifamily skill training; DBT family therapy) have been developed to target the family environments. These seem a natural extension of DBT for several reasons: 1) As stated, the etiological hypothesis of DBT identifies the key role of the environment in the development of borderline behavior patterns; 2) DBT is a treatment based on a transactional model that looks at interactions of biology, individual behavior, and environment, and their mutual effects; not modifying these present-day interactions may perpetuate maladaptive patterns; 3) Studies indicate that family members of BPD patients have their own emotional vulnerabilities and have often been raised in invalidating environments (Zanarini, Gunderson, Marino, et al., 1990; Multiple Family Therapy Group—New York Presbyterian Hospital). DBT for families therefore complements individual DBT, targeting both the whole family environment and the individuals' behaviors within it.

Thus, family interventions in DBT may be considered: 1) as psychoeducation, to augment individual DBT; 2) as a treatment of the family per se, targeting improvement of family relationships and satisfaction; or 3) as both. The present article introduces and describes one short-term family intervention designed both to augment individual DBT outcomes and to improve family relationships and satisfaction, which we call DBT-Family Skills Training (DBT-FST).

DBT-FST

Despite the increasing number of individuals with borderline personality disorder who present for treatment, and the increased attention this disorder has received in the past decade, no specific family treatment to date has been designed and documented as effective with BPD patients and their relatives. Work based on DBT is now ongoing at the New York Presbyterian Hospital-Cornell Medical Center-Westchester Division (P.D.H.) and at the University of Nevada, Reno (A.E.F.).

DBT relies on the behavioral principles of operant conditioning, positive and negative reinforcement, punishment, extinction, as well as on classical conditioning. To the degree that families have reinforced maladaptive patterns in the patient, and punished (invalidated) effective behaviors, teaching the family to reinforce effective functioning in a consistent manner (validation of the valid) can be a potent change intervention. Similarly, teaching the patient to reinforce effective parental interactions, which in turn, facilitate his or her more effective repertoires, can assist in that process. Instruction and a partnership in mutual reinforcement of skillful behavior between patient and family member(s) offer more possibilities for effective environmental changes.

Dialectical Behavior Therapy-Family Skills Training (DBT-FST) is a structured, behaviorally oriented family intervention that includes both acceptance and change strategies and skills. Standard DBT includes four essential functions of treatment (Linehan, 1993a): 1) skill acquisition (through skill training); 2) skill generalization (application or transfer of skills) to the environment (usually through phone or milieu consultation); 3) balancing and treating the therapist (through a consultation team and/or supervision); 4) enhancing motivation of the patient (through individual therapy). DBT-FST includes the first two components directly. Skill acquisition is promoted through periods of instruction and rehearsal, and skill generalization is promoted through periods of discussion and practice among family members, both in session with available consultation from group members and leaders, and at home. Therapist skill acquisition and balanced comportment are maintained by the consultation team (as in individual DBT). Finally, patient motivation (behavioral

disposition, the context in which effective behaviors are emitted and reinforced) is maintained by individual DBT initially, and also by the DBT-Family Skill Training.

DBT-FST incorporates another component called "structuring the environment." This component provides the opportunity to combine further the two functions (skill acquisition and skill generalization), affording patients a setting in which to practice new skills with their family members, their genuine in-vivo environment. Thus, including families in DBT can function at multiple levels. DBT-FST may be delivered to families individually, or in multifamily groups; the functions are largely the same. The multifamily group format will serve as the template for describing DBT-FST throughout most of this article. A more comprehensive explanation of the use of DBT with families,couples, and parents across different modes is available in the forthcoming book, *Dialectical Behavior Therapy with Couples and Families* (Fruzzetti, Hoffman, & Linehan, in press).

Facilitated by DBT's nonjudgmental framework, DBT-FST offers the possibility of significant emotional and behavioral improvements in the whole family system as well as for the individuals in that system. This is accomplished through: 1) presenting the biosocial model to patients and family members in a nonblaming manner similar to the approach employed in psychoeducation models; 2) offering support and education to family members in the form of teaching DBT skills; and 3) reinforcing skillful behaviors (in particular using rehearsal and feedback) through increasing the levels of empathy and validation in the family. In some ways analogous to programs that have been available to other psychiatric patients and their families (McFarlane et al., 1995; Miklowitz & Goldstein, 1997), DBT-FST provides both the relatives and the BPD patients the opportunity to learn nonblaming ways of understanding each other, new and more effective ways to manage problems, and a forum in which to discuss and resolve family issues. Thus, the dialectical target is changes that benefit *both* an individual *and* his or her family member (and their relationship). Solutions to problems are only generally considered until this synthesis is achieved.

The choice of a multiple family group format was instrumental to the design of this mode of the intervention for several reasons: 1) The setting offers an opportunity for modeling that is unique. Newer group members are able to witness more "advanced" families communicate, problem-solve, and demonstrate skill application. These experiences assist novice families in their goal setting and help them target behavioral patterns they want to modify in their relationships. At the same time, more senior families also have the experience of remembering and reflecting on their own past behaviors as they view the struggles of new group members, recalling their own skill deficits when they began. 2) The importance and significance of the dialectic of acceptance and change is facilitated and frequently experienced in the group setting. Participants, both patients and relatives, are often more able to accept problematic behavior in a nonfamily member than they are in a member of their own family. Through proxy, they may recognize their own ineffective behavior, helping in turn to accept "what is" in a given moment. Through the group experience, they "learn by analogy with much less anxiety than is usually associated with such learning" (Laqueur, 1972, p. 403) that radical acceptance is often an important first step toward change. 3) Cross validation is another frequent and valuable occurrence in a multifamily group. A parent from one family may be able to validate an "adult child" in their present efforts while the natural parent may still be focused on a past behavior. This interaction not only serves the "patient" but also may prompt the "stuck" parent to look at the situation from a different perspective. 4) The cost efficiency of the group format cannot be equaled. Two therapists can treat up to 30 individuals in 90 minutes, certainly relevant to the era of managed care. From a behavioral perspective, the multigroup format also affords a mini in-vivo opportunity for modeling, rehearsal, immediate feedback, coaching and encouragement, shaping, extinction of problem behaviors, identifying the conditions in which less and more effective behaviors occur, identifying reinforcers and punishers, and clear targeting.

Dialectical Behavioral Therapy-Family Skills Training includes psychoeducation,skill acquisition and generalization, and consultation components, and is primarily designed with four goals in mind. *The first goal is to educate family members on two aspects of borderline personality disorder:* a) its characteristic behaviors and b) DBT's biosocial theory of emotion vulnerability and dysregulation and the invalidating environment. This instruction helps family members to understand behaviors that often have been both terrifying and angering. Families are often confused about the legitimacy of BPD because of the sometimes extreme distress of the patient and his or her frequent inconsistencies in functioning. The term "borderline" *personality* disorder" itself also sends a confusing message since it is generally believed that one should be able to control one's personality. With this kind of belief, anger is prevalent and critical comments directed at the patient are frequent. Describing the behaviors that define the disorder often highlights for relatives some of the very same difficulties they share with the identified patient, and family members often acknowledge that they, too, have some "borderline" traits. In addition, understanding puzzling, annoying, or frustrating behaviors as part of a disorder provides a framework in which family members can be more empathic about the client's struggles.

Problem behaviors are described in a nonjudgmental way, which is both a core value and a core skill in DBT (mindfulness). In DBT-FST, problem behaviors of any individual may be considered to *function* in various ways, despite being ineffective in other ways. Exploring patterns from this perspective may help to reduce invalidating cycles that exist in families. This hypothesis is well-supported by attribution theory—that one's perception of a problem determines one's attitudes, beliefs, and actions toward that situation. In part due to lack of knowledge, over-learned patterns of judgment or

criticality, family members may perpetuate the invalidating environment by their responses to current patient behaviors. Information in DBT-FST is presented in a nonjudgmental, nonaccusatory manner. In fact, the term "incompatible environment" may be used initially instead of "invalidating environment" because it may be experienced by parents as ascribing less blame. Relatively quickly, however, the latter is introduced and soon the two become interchangeable, without judgment.

The second DBT-FST focus/goal is to teach family members new intra-family communication that targets creating and maintaining a mutually validating environment. This is done by presenting new ideas and terminology for emotions, behaviors, and/or ways of thinking, from a new perspective. The new language provides a more effective way of speaking. For example, it is much easier to hear that one perceives you as being in "emotion mind" (when one's thinking and behavior is heavily influenced by one's current emotional state) rather than your being "too emotional" or "illogical." Similarly, it is more useful and constructive to be told that you are in "reasonable mind" as opposed to being "void of emotion." This new vocabulary becomes a highly valued and important tool in diminishing the invalidating cycle.

The third goal is to help family members become less judgmental toward each other, and to accept a basic dialectical tenet of DBT-FST: that there is no one truth nor any "absolute" truth. Extensive family work with borderline personality disorder patients and their relatives reveals that judgments and criticisms are prevalent (Multiple Family Therapy Group-New York Presbyterian Hospital). This often flows in all directions: from parent to offspring, child to parent, partner to partner, and so on. A primary target in DBT-FST is for participants to become much more aware of, and subsequently reduce, their own judgments and levels of hostility and criticality. Again, with DBT concepts and terminology applied to family relationships, it may be much easier for family members to hear one another, and increasingly to respond in a validating manner.

The fourth goal is to provide a safe forum where clients and family members can have discussions about intense issues such as self-destructive behaviors, feelings of rejection, anger, sadness, or suicide thoughts or attempts. In the second half of each session, the Consultation Hour (described below), where the skills are applied to family issues, topics such as resolving the closeness versus independence false dichotomy, abuse, invalidation, and observing one's limits come up frequently. Through use of the DBT skills, a component of which teaches one how to communicate more effectively (Interpersonal Effectiveness; Linehan, 1993b), topics previously considered taboo are often discussed in ways that promote self-respect while still maintaining the relationship. The balance of enhancing self-respect, maintaining the relationship, and still achieving immediate goals, is a central target in DBT.

Group Structure and Strategies

The forum for the treatment is a 6-month (24-week) series that meets for an hour and a half on a weekly basis with a group of from 6 to 9 families. BPD clients may invite anyone to participate, and rarely do not attend themselves if a relative comes. In fact, in the New York Presbyterian Hospital group (P.D.H.), out of the approximately 110 families who have participated, only 6 patients have chosen not to participate. When done in a group mode, two therapists are often used for both practical (modeling) and theoretical (the dialectic of multiple perspectives) reasons.

Prospective participants are oriented prior to entrance into the group. This meeting serves several purposes. One is to assess the appropriateness of members entering the group, screening out individuals who may be too psychiatrically impaired to participate in a group milieu. Exclusion criteria include behaviors of an *untreated* mental illness, that is, schizophrenia or bipolar disorder; thus far this has not occurred. Second, the orientation meeting is also used to gather information on pretreatment variables in order to evaluate the effectiveness of the program. Several assessment and research interviews as well as a battery of self-report instruments are administered to obtain data on the family system prior to the intervention. Finally, this pretreatment meeting is also used as an opportunity to make a connection with the new family members so that when they start the group they have at least a beginning relationship with one or both group leaders. This provides a preliminary alliance and facilitates support when they initially come into the group.

The definition of a family member is quite broad, resulting in a heterogeneous constellation of group members. Participants have included parents, spouses, partners, children, and siblings, sometimes from the same family. For example, several married women have attended with both their spouse or same-sex partner, as well as their parent(s) or their adult children or stepchildren. This diversity adds to the richness of the group, offering the opportunity for exposure to a variety of life experiences. In addition, an adolescent patient is often more able to hear feedback from a non-"patient" teenager who attends the group. These kinds of interactions can help to depathologize appropriate separation behaviors for boththe "identified patient" and his or her parent. Similarly, a patient who is a mother can support a nonpatient mother in her struggles with her BPD child. The only exclusionary criterion is age. No one under 16 is permitted to attend regardless of how "mature" a parent may perceive that individual. This limit is observed not only for the youngster in question, but also for the other group members who might feel uncomfortable bringing up certain topics with a young teenager.

The sessions, 90-minutes each, are divided into two parts. The first 45 minutes involve a didactic component in which traditional and family-specific DBT skills are taught with a particular emphasis on family relationships. *These DBT skills*

center on five modules: 1) Interpersonal Effectiveness skills help to reduce interpersonal chaos. Included are skills designed to help balance a) objectives or goals in a specific situation, with b) maintaining the relationship, and c) maintaining (or enhancing) self-respect. 2) Mindfulness skills help to reduce confusion about self and decrease cognitive dysregulation. Consistent with individual DBT, clients are taught how to observe, describe, and participate in experiences in a nonjudgmental, effective way, focusing attention on one thing at a time. The focus here is both on observing, describing, and participating in one's own experience (mindfulness of self) and on being able to observe and describe the actions, feelings, and so on, of significant others in a nonjudgmental way (mindfulness of others). 3) Emotion Regulation skills help to stabilize and manage labile emotions and to decrease painful negative emotional arousal. As part of the core theory of BPD, patients and family members are taught new ways to think about and understand emotions and new strategies for managing them, including a) decreasing emotional vulnerability, b) reducing unnecessary emotional suffering, and c) strategies for changing painful emotions over time. 4) Distress Tolerance skills help to reduce impulsive behaviors that likely lead to further dysregulation. These skills include many strategies for surviving crises, accepting reality, and tolerating distress in order to allow natural change. 5) Validation skills reduce one's own dysregulation (self-validation) and improve relationships (validating others). These skills include a) understanding the forms and functions of validation and invalidation, b) specific skills to identify targets (emotions, opinions, effective behaviors) for validation, and c) the verbal and communication skills to validate effectively. The first four modules mentioned (Interpersonal Effectiveness, Mindfulness, Emotion Regulation, and Distress Tolerance) are adapted directly from the *Skills Training Manual* (Linehan, 1993b). The last module (Validation) is adapted both from Linehan (1997) and Fruzzetti (1995, 1996), and is elaborated in *DBT with Couples and Families* (Fruzzetti et al., in press).

Consistent with individual DBT, these modules provide skills believed to help regulate emotions, reduce impulsivity and behavioral dyscontrol, improve concentration and awareness, enhance consistent self-repertoires, and improve relationships. These are all targets because these problems are the *consequences* of living in an invalidating environment. Teaching patients and family members how to validate and how to create and maintain a validating environment, will target for change the very characteristics or basic processes that co-create or maintain the disorder. Thus, teaching all five sets of skills maximizes the chances for improving the environment to potentiate individual treatment and promote emotion regulation, and fosters individual skills to maximize the potential for creating and maintaining a validating environment thatenhances relationship quality for its own sake. Additional skill modules have also been developed for specific family constellations (relationship mindfulness for couples, problem-solving skills, and DBT parenting skills; Fruzzetti et al., in press).

In addition to the specific DBT skill modules and materials, topics specific to family relationships and systems are introduced, again within a DBT framework. These include subjects such as family roles, themes, myths, secrets, as well as the concepts of empathy and how it relates to validation, and the importance of these issues in family interactions.

The first half of each meeting (45-minute component) alternates on a weekly basis between a lecture and a homework review/new skill acquisition (see Table

Table 1
First Month's Schedule for DBT-FST Group

Week 1	90 min-Psychoeducation
Week 2	90 min-Psychoeducation
Week 3	45 min-Core Mindfulness Skills
	45 min-Consultation/skill application
Week 4	45 min-Homework Review/skill acquisition
	45 min-Consultation/skill application

for example of first month's schedule). In the latter, participants bring in their written assignments relevant to the previous week's lecture. The second half of every meeting is a multiple family skills application group. In a consultative manner, participants bring up a family issue on which they would like to focus. This component offers not only a forum in which to talk about family relationships, similar to multiple family therapy groups, but, as a behavioral treatment, it also provides an essential opportunity to put the DBT skills into practice, as noted above. Group leaders role-model for the group-skill generalization and participants also serve as collaborators and coaches with the common goal of helping a particular family implement their DBT skills as they work on resolving their presenting issue. Often members will be asked to reframe a point they are making, slow down to employ relationship mindfulness (observing and describing the other person nonjudgmentally), are coached to use a DBT skill to help them practice more effective communication, or engage in behavioral analysis and problem solving.

Orientation to the family skill training group, as in DBT, is essential and occurs in the first two sessions. Because the

group is open-ended, with new members joining once each month, these first two orientation lectures are repeated to all new attendees separately, usually the hour and a half prior to their entrance into the program. During this time individuals are informed about the structure of the program and asked to make a commitment to treatment, parallel to what is requested in standard DBT treatment (Linehan, 1993a). It is also clearly stated that everyone in the group is a client, that there is no distinction made between "patient" and relative: everyone is there to learn and change. In addition, participants are asked to abide by certain rules, including: 1) striving to adopt the DBT-FST Four Basic Assumptions as a major goal: a) there is no one truth nor any absolute truth; b) everyone is doing the best he or she can; c) everyone needs to try harder; and d) everyone needs to (try to) interpret things in a mindful/nonjudgmental or benign way (adapted from Linehan, 1993a); 2) honoring the confidentiality of all participants (what is said in the room remains in the room); 3) prioritizing session attendance and announcing upcoming absence; 4) completing homework assignments.

This first agreement (set of assumptions) is usually difficult for people. Some of its tenets—in particular, everyone is doing the best he or she can, and interpreting things in a benign way—are oftenhard to accept at first. These two are often brought up in the context of having a family member who engages in destructive behaviors, the knowledge of which may upset family members. Family members struggle with framing a self-injurious act benignly or accepting that the individual is doing the best she or he can. It is hard for relatives initially to accept some of these ideas (especially, that the patient is doing the best she or he can), and meaningful exchanges often develop. The ensuing discussion is a wonderful opportunity to set the tone for accepting other people's viewpoints, agreeing that there is no one truth and that others' perspectives are valid. Additionally, Assumptions 1a and 1b provide perfect examples of dialectical thinking.

The atmosphere set by the leaders in DBT-FST is similar to the collaborative approaches already mentioned with other diagnostic problems, and is itself designed to be therapeutic. Many relatives with a family member who has had multiple difficulties for a long time, have had prior experiences with mental health professionals. Frequently they report that they were told that their involvement and relationship were not helpful. Sometimes "parentectomies" have been recommended by previous therapists (Jones, 1989). Therefore, when they are invited by their relative to participate and join in a program that may be mutually beneficial, they often perceive the invitation itself as a validating experience. Family members attribute this positive perception to several factors: 1) their relative wants to participate with them in a joint effort to improve their relationship; 2) they are offered an opportunity to acquire skills to help their loved one; and 3) their own suffering is also being acknowledged (validated). Rather than be seen as an adversary, they are encouraged to become part of the team with their relative. This already sets the collaborative tone necessary for any successful family and/or DBT treatment.

Prior to entering the group, family members often express their need for a support group, a place where they can talk about the disorder and the impact it has had on their lives. While the group is certainly supportive in the usual sense of the word, a focus remains on validation: reinforcing the valid, effective behaviors of family members and not reinforcing dysfunction. If they are skeptical about the "patient" being in the same group with them, they quickly become converts after a group or two. Drop-out rate has been low, 20%, which, for this diagnostic population (in individual psychotherapy), is quite good (Koenigsberg, 1997). Participants find that they are able to discuss constructively, with their partner or family member present, what may have felt like taboo or inflammatory topics, such as family burden or how to observe one's limits. Thus, the involvement of both client and family members provides an optimal therapeutic environment. Consistent with the DBT principle of "consultation to the patient" to help the patient be more personally skillful (contrasted with the therapist intervening on the patient's behalf; see 1993a), this open communication approach reduces patient suspicions about what is being told to the family and what the family says about the patient. In addition, it sets the tone and exemplifies the goal of equalizing power across family relationships.

This alliance can also be extended to another DBT strategy. Participating family members can be trained to "coach" their borderline relative at certain key moments. Knowing the DBT philosophy, its language, and skills, offers relatives and patients opportunities to work collaboratively to make important changes, or simply to tolerate distress more effectively. This new role for family members may also assist in enhancing motivation, another DBT function. Family members, by changing what they reinforce, by reducing the level of judgmental reactivity, by cheerleading progress and potential, and by coaching skills, can help improve the patient's motivation, create opportunities for her or him to initiate more successful behaviors, and provide more reinforcing consequences (warmth, appreciation) for skillful or effective behaviors.

To help insure success, relatives must also learn about the concept of "observing limits." DBT makes a distinction between "observing" limits and "setting" limits, recognizing that situations can change, that there is no one correct path toward an improved quality of life, and that relationships, goals, and self-respect must be balanced continuously (Linehan, 1993a). This concept of observing one's limits relies more on context and less on rules, and is more oriented to being aware of the present moment without judgment (of either party). This particular concept can be as important to family members as it is to therapists and to patients. People will endure more fully and in a more balanced and helpful manner if they continue to monitor and observe (and even extend at times) their own personal limits. Families can often find themselves going well beyond what they want to do, and they may later resent it and blame or judge themselves or their partners and family members. Educating and supporting them toward respectful, flexible, noncondescending ways of asking patients to respect

their limits at any given time is essential.

Another characteristic of DBT-FST centers on the shared task of learning something together. An esprit de corps can develop as participants strive to understand and acquire DBT skills. A borderline client will often answer a question posed by a parent, will provide a better explanation of a skill that may be confusing, or even, at times, be the DBT skill lecturer. Senior group members will sometimes offer to provide a lecture on a skill that he or she has mastered or has been particularly helpful to them. These offers have come from both patients and relatives who, after learning a skill during an earlier series, want to share their use of it with others. "Guest lecturers" usually report even greater skill mastery after teaching it to others. Group members almost universally have found these opportunities effective. It can be quite motivating to hear how a skill has been used in someone else's life, and the level of enthusiasm may be encouraging and contagious.

Finally, but of equal importance, is that DBT-FST acknowledges that family members are also individuals, and it offers to them the opportunity to obtain the benefits of DBT independently from their child's difficulties. As stated, parents of borderline patients are frequently found to suffer from emotion dysregulation problems themselves, and may also come from invalidating environments. Offering treatment for them can do several things: 1) it can provide them with much needed skills and much needed support; 2) it can help them better understand their own struggles; and 3) it can provide them with an increasingly validating environment. This kind of support can assist them in shifting their responses to the patient, to becoming more validating, nonjudgmental, and supportive, and also providing skills for themselves in their own struggles.

Clinical Examples

One of the most popular sessions, because of its direct applicability to family relationships, is the lecture that deals with interpersonal effectiveness. It provides a concrete structure for dialogue that is often very intense. The particular richness of DBT-FTS is, of course, thatthe actual family members are in the room. This eliminates the necessity of role-plays to learn and practice the skills, and thus provides a unique opportunity to implement DBT skills.

Once an atmosphere of trust and safety develops, people may take risks, bringing up very intense and important issues. Group members will, for example, coach each other to use DEAR MAN (Linehan, 1993b, p. 125)—an acronym for a set of interpersonal effectiveness skills—in order to be more effective in achieving their objectives. People actively participate in helping each other put the skills into practice, and a sense of mastery and accomplishment is usually experienced by both the person being coached and those doing the coaching.

In one group, a patient who was very angry at her parents tried to communicate her rage to them. When she first presented it, she came across in an attacking and hostile way. Her parents shriveled up in their seats and were verbally paralyzed. Someone coached her by asking if she could rephrase what she was saying using DEAR MAN skills. This stands for: **D** = *describe* specifically the situation: "Almost every time I try to talk to you, you leave the room and say that you don't want to listen to me"; **E** = *express* how you feel: "This makes me very angry"; **A** = *ask or assert;* "When I start to talk to you, could you give me your attention and not leave the room"; **R** = *reinforce* the other person: "This might avoid the fighting that happens when I first come over to your house"; **M** = *mindfully;* **A** = *appear competent;* **N** = *negotiate,* if necessary.

After assistance from the group the client was able to be considerably more effective and nonthreatening in her communication. Understandably, the first response from her parents was totally different. They could hear and comprehend what she was saying, realizing that they, as well as their daughter, were initially in "emotion mind." Her second presentation elicited a different response, and facilitated a different attitude and set of verbal responses. They validated her feelings as well as her belief: in this case, that she was put in the middle of their marital relationship, and how this affected her. They were able to understand what she was feeling and conveyed to her that they recognized that their behavior (validation) had a significant impact on her. She then, in turn, was coached to acknowledge their validation of her, thereby demonstrating the importance of reciprocal reinforcement of effective in-relationship behaviors.

To continue with this example, the patient was asked what her priority was in her interaction (also an interpersonal effectiveness skill). This concept comes from one DBT lecture that focuses on teaching people the importance of first identifying what they want to occur in an interaction. There are three priorities identified in DBT interpersonal effectiveness: 1) objective effectiveness, 2) relationship effectiveness, and 3) self-respect effectiveness. From this base, one can approach a discussion with an identifiable goal. Referring back to the young woman who approached her parents: she first said she wanted them to apologize to her. But, in thinking about it in DBT terms, she realized that what she really was looking for was a way to maintain her self-respect. She felt that her feelings were usually disregarded and that she was not understood, which increased her self-invalidation and made her feel worse (be judgmental) about herself. After using the skills, she reported feeling more competent; she felt she had expressed her feelings in an effective way that was then acknowledged.

Another example illustrates the use of the emotion regulation skills. The focus here is on being able to identify an

emotion, to establish what triggered it, and then to be able to deal with it in an effective way (tolerating it or changing it). BPD patients usually feel that they are controlled by their emotions, and their behaviors are mood dependent. Regulating one's emotions rather than using problematic or dysfunctional behaviors to reduce or avoid them (for example, cutting, aggression, substance use) is a major tenet in DBT. Because family members often are emotional triggers for each other, learning this skill together, as a family, may be very potent.

An illustration of the effectiveness of these skills occurred in an interaction that took place between a 20-year-old and her mother. They had a fight during the car ride to the session, and both felt that they could not tolerate getting back into the car together. Their emotions were so high that they had trouble making any sort of eye contact. Each one's emotional experiences were tracked by using a diagram that represented a model for understanding emotions (Linehan, 1993b, p. 137). With a specific model to use for describing their emotions, participants are taught a more constructive and effective way to have an intense interaction while at the same time defusing some of the anger. The dialectical target (mutually validating environment, mutual individual enhancement) can be addressed.

DISCUSSION

Although there are yet no data from randomized clinical trials to document the efficacy or benefits of DBT-FST (studies are ongoing), its success can be suggested in other ways at this time. For example, a recent, controlled, within-subject design study demonstrated improvements in individual DBT targets with brief DBT-FST (Fruzzetti, 1998), and consumer satisfaction with multifamily groups is very high (Multiple Family Therapy Group-New York Presbyterian Hospital). In the latter, on any given week, at least 30 people, representing on average 12 families, attend the weekly meetings at the New York Presbyterian Hospital. Some clients and relatives have chosen to remain for several cycles of DBT-FST, finding that they are able to use the concepts and skills with increasingly difficult problems. With their developing sense of mastery, several have even been DBT-FST lecturers (and outstanding ones at that). Their appreciation and commitment to this modality of family treatment is frequently verbalized. For example, one father strongly relayed how much the family therapy has meant to his wife and daughter and, even after extended participation in a multifamily group, that it would be hard to terminate. He felt that it had provided their family an opportunity for a new way of communicating and the chance to have a good relationship with his adult child, one that had not existed prior to entering DBT-FST. A postscript to their termination in the group was their decision to continue to meet together every other Monday night for dinner rather than in the group. This was truly new behavior for them.

Other families express similar positive sentiments. They find that the combination of acquiring DBT-FST skills, the opportunity to apply those skills in the group, and the shared experience both intrafamily and interfamily, has helped effect change with the most significant people in their lives. Although future research has yet to demonstrate whether altering these family relationships and communication patterns will modify the course and rate of relapse of BPD, its significance has already been felt by its participants.

More rigorous testing of the efficacy of this application, both to improve the outcome for the identified patient and to improve the quality of the family environment, are currently underway. Such efforts will likely lead to further modifications of the program so that we can continue to improve treatment for borderline patients and their loved ones.

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