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DBT-A and Parental Inclusion in Skills Training Groups

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DBT-A and Parental Inclusion in Skills Training Groups

by

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MSW Clinical Research Paper

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The Clinical Research Project is a graduation requirement for MSW students at St. Catherine University/University of St. Thomas School of Social Work in St. Paul, Minnesota and is conducted within a nine-month time frame to demonstrate facility with basic social research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee and the university Institutional Review Board, implement the project, and publicly present the findings of the study. This project is neither a Master's thesis nor a dissertation.

Abstract

The purpose of this project is to determine whether parental inclusion in skills training groups within Dialectical Behavior Therapy for Adolescents (DBT-A) works as an intervention to help self-harming female adolescents. This is a systematic review of 16 articles related to adolescent girls and self-harm, DBT-A and the inclusion of parents in their skills training group. It provides a theoretical portion about the prevalence of girls engaging in deliberate self-harm (DSH) followed by background information around DBT and DBT-A. The research narratives show effectiveness of parental inclusion in treatment through different study designs. Studies include different settings and diagnostic criteria and includes parent perspectives. For clinical Social Work practice, DBT-A can be an important additional treatment variant to refer to. Given that society will be dealing with increasing numbers of self-harming adolescents in the future, aiming for outpatient treatment as opposed to inpatient, and decreasing the costs for the community, DBT-A may be the answer for many families to participate in.

***Keywords:* adolescent girls, self-harm, emotion regulation, DBT-A, family component**

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DBT-A and Parental Inclusion in Skills Training Groups

Self-harming behavior among adolescents is increasing and it represents a significant public health concern (Heilbron & Prinstein, 2008). For example, in 2009 general medical Emergency Departments treated 74,905 youths 10 to 19 years old after deliberate self-harm (Bridge, Marcus, & Olfson, 2011). Ryan, Allen Heath, Fischer, and Young (2008) state that 1% to 4% of the U.S. population engages in superficial self-harm (SSH). However, they add that this behavior is much more prevalent in adolescents, ranging from approximately 14% to 39%.

Nock (2010) defines deliberate self-harm (DSH) as “the direct and deliberate destruction of one's own body tissue in the absence of suicidal intent” (p. 1). Examples of DSH are: hitting, picking, cutting, biting, or burning the skin and self-poisoning. The most common form of DSH is self-cutting or carving and most people will cut their arms or feet (Laukkanen, Rissanen, Tolmunen, Kylma, & Hintikka, 2013). DSH can negatively affect school and relationships because those who engage in self-harm may have to miss classes to change bandages or avoid social occasions to prevent people from seeing the scars, per the National Alliance on Mental Illness (NAMI, 2016).

NAMI (2016) links self-harm with suicidal ideation. Indeed, adolescents engaging in self-harm are four times more likely to die by suicide, indicating that self-harm is a strong predictor of attempted and completed suicide (O'Connor, Rasmussen, & Hawton, 2012; Brent et al., 2013). Harriss and Hawton (2008) concluded after their study that: “The rate-ratio of DSH to suicide is 36 based on annual person-based rates of DSH episodes and is nearly five times higher in females than in males” (p. 650). Even though there is more awareness about the link between

self-harm and suicide attempt, there still has not been a substantive reduction in suicide death rates over the past 60 years (Ougrin, Tranah, Stahl, Moran, & Rosenbaum Asarnow, 2015).

DSH can stimulate the body's endorphins or pain-killing hormones and therefore function as a release or replace emotional numbness (NAMI, 2016). Brady (2014) studied the different functions of DSH, such as: breaking through the isolation of a depressive state, "communicating" emotional concerns which are denied in the family of origin, compensating for feelings of failure in difficulty managing emotions and social relations or feeling overwhelmed by emotions and challenged by the task of communicating. An invalidating family environment and peer influences are also factors associated with DSH (Sim, Adrian, Zeman, Cassano, & Friedrich, 2009; Hargus, Hawton, & Rodham, 2009). Self-harm by family or friends, descriptive norms, impulsivity, and the experience of negative life stress distinguish adolescents considering self-harm from adolescents who actively engage in self-harm (O'Connor et al., 2012). Laukkanen et al. (2013) add that DSH is strongly associated with emotion dysregulation. Given these problems with self-harm, interventions have been created to help decrease it among adolescents. Linehan (1993) suggests that self-harming behavior stems from a combination of biological and environmental factors.

Linehan is the founder of Dialectical Behavior Therapy (DBT). Rathus and Miller (2002) adapted the DBT program to adolescents (DBT-A). This program provides specific ways to teach adolescent girls how to emotionally regulate. It involves active family participation and it teaches family members the same skills (through skills training groups). Given the strong family component of DBT-A, the purpose of this study, following the literature review, is to determine whether parental inclusion in skills training groups within DBT-A works as an intervention to help self-harming female adolescents.

Background

Dialectical Behavior Therapy (DBT)

DBT was created by Marsha Linehan (1993). Linehan found that for many highly sensitive and emotionally reactive natured people Cognitive Behavior Therapy (CBT) was ineffective. People felt judged and invalidated by the direct focus on behavioral change (Linehan, Miller, & Rathus, 2007). DBT blends three theoretical positions: behavioral science, dialectical philosophy, and Zen practice. It helps the client learn and apply skills to decrease emotion dysregulation and unhealthy ways of coping with strong emotions. DBT includes individual psychotherapy, skills training groups, phone consultation, and a therapist consultation team. “Core skills and teaching modules include emotion regulation, interpersonal effectiveness, distress tolerance and mindfulness” (Freeman, James, Klein, Mayo, & Montgomery, 2015, p. 125). Literature states that DBT is highly effective in treating Borderline Personality Disorder (BPD) in adult women (Woodbury & Popenoe, 2008). Miller and Rathus (2002) adapted DBT for adolescents (DBT-A), because many adolescents engaging in self-harm, own traits of BPD. The combination of emotion dysregulation and an invalidating environment often appears to be the leading cause of DSH. Many adolescents still live in the environment; therefore, it may not only be useful, but essential to involve the environment (i.e., the family) into treatment.

One of the ways DBT-A does that is by offering families skills training groups. A DBT-A family skills training group aims to decrease family interactions that contribute to the adolescents’ self-harm. Another goal is to reduce family behaviors that interfere with treatment and family interactions that interfere with the family's quality of life (Miller & Smith, 2008). The same article also shows that the exposure of teens and parents to other families promotes connectedness and support. An important finding in the Woodberry and Popenoe (2008) study is

that parents involved in DBT-A skills training group indicated that the treatment reduced their own depressive symptoms as well.

The dialectical framework. Miller et al. (2007) explain that the dialectical framework in DBT aims at “the tension between thesis and antithesis which produces change and the transactional process between the individual and the environment” (p. 36). DBT focuses on acceptance and change. The goal is to bring out the opposites, placing the concept of balance at the center of the treatment.

Emotion dysregulation. Sim et al. (2009) emphasize that it is a parent’s responsibility to teach children about emotions. It is important to learn how to identify and express emotions in a healthy way. Children also need to gain awareness of other people's emotions. From a DBT perspective, someone struggling with emotion dysregulation is described as: “A person who has a higher sensitivity to emotional stimuli, engages in highly emotional responses and has a slow return to emotional baseline” (Miller et al., 2007, p. 42). Emotion dysregulation often results in cognitive and behavioral problems. It interferes with the development of stable interpersonal relationships and a stable identity. For example, the adolescent will look at others on how to act, think and feel.

Biosocial theory. This theory considers the biological and social factors. Some individuals have a high vulnerability to emotion dysregulation, which can result in DSH (Miller et al., 2007; Nock, 2010). Salsman & Arthur (2011) add that:

problems with emotion dysregulation, interpersonal conflict, impulsivity, cognitive dysregulation, and self-dysregulation are the result of the transaction between biological predisposition (a high emotional sensitivity, a high extremity

in reactions and a slow return to baseline after experiencing a surge in affect) of individuals and an invalidating environment (p. 20).

Combination of emotion dysregulation and an invalidating environment. In the study on parental control, researchers concluded that consistent parenting has great effects on emotion regulation (Luebke, Bump, Fussner, & Rulon, 2014). In addition to that, BPD, or borderline characteristics, such as maladaptive solutions to overwhelming, intensely painful negative affect, is often the result of the transactional pattern between emotion dysregulation and an invalidating environment (Miller et al., 2007; Sim et al., 2009). The cycle of invalidation that occurs in some families needs to be reduced. The only way to do that is to include families in skills training group (Rathus, Miller, Campbell, & Smith, 2015).

Emotion regulation skills. Emotion regulation skills are taught through mindfulness skills where individuals learn to observe and describe emotions. There is a focus on self-care and building a sense of mastery. Another mindfulness skill is to either act opposite to current emotion or to tolerate current affect (Miller et al., 2007). Steps that teach ‘opposite action,’ are designed to treat the spike in emotions that adolescents often experience that lead to urges for ineffective behavior, such as DSH (Salsman & Arthur, 2011).

Invalidating environment. An invalidating environment actively rejects communication about private experiences, punishes displays of emotions and oversimplifies problem-solving. Individuals do not learn to validate themselves, how to label and regulate emotions, how to tolerate distress, or when to trust their emotional responses. They develop problematic emotion regulation strategies that oscillate between suppression and extreme outbursts, high perfectionism, and sensitivity to perceived failure (MacPherson, Cheavens, & Fristad, 2013;

Salsman & Arthur, 2011). To improve family functioning in some highly conflictual families, teaching the skill of validation can be powerful (Rathus et al., 2015).

DBT-A

Growing evidence suggests that DBT-A is a promising treatment approach with the largest effect size for youth engaging in DSH (Freeman et al., 2015; Ougrin et al., 2015). Findings are associated with reductions in inpatient hospitalizations and behavioral incidents like violence toward self and others. DBT-A includes several adaptations of standard DBT such as: a decrease in treatment length from 12 months to 16 weeks to make the program more appealing to adolescents, the incorporation of age-appropriate terminology, the inclusion of family members in skills training groups and the addition of an adolescent-specific skills module called: “Walking the Middle Path.”

Family component in DBT-A

Even from a non-DBT perspective, it can be helpful to include the family in therapy sessions. For example, Feng et al. (2009) concluded from their study that parenting skills determine the vulnerability in emotion regulation and later depressive symptoms. NAMI (2016) adds that DSH often causes feelings of shame and guilt. Family participation in therapy may reduce these feelings, considering the focus is more on the family as a system and less on the individual.

The family component in DBT-A distinguishes the program from Therapy As Usual (TAU) (Rathus & Miller, 2002). Oftentimes, the adolescent is still living in the invalidating environment in which she learned dysfunctional patterns. The overall focus of DBT-A is on the interactions between family members.

Parents are considered partners in treatment. An example of partnering with parents is through contingency clarification. This means to work out a plan together as how to best respond to the adolescent engaging in self-harm. For example, “either reducing attention to DSH or responding with slight aversive consequences, while communicating to the adolescent that parents will attend positively to adaptive behaviors” (Miller et al., 2007, p. 193). Another example is to psycho-educate parents and help them empathize with the emotional pain that is driving the adolescents’ extreme behaviors in a nonjudgmental way (see family therapy); or to prepare parents to expect ‘ups and downs,’ so that they can stay more consistently connected to the adolescent. Other skills include helping parents reduce invalidating and increase validating communication (see skills training group); helping parents increase the size of the adolescent’s support network; and modifying family interactions by reinforcing adaptive behaviors. In the case of a suicidal adolescent, it can be extremely helpful to help build a crisis plan together with the family to give them a clear course of action during a chaotic time. This will also provide the parents a sense of support (Miller et al., 2007).

Skills training group. Parents are included in skills training groups where they will learn DBT skills and the same vocabulary (skills generalization) as their children; they will also learn to enhance their ability to provide validation and support and to reinforce skillful behavior. The family learns how to communicate effectively, such as practicing problem-solving skills to find a middle ground between viewpoints (see *Walking the Middle Path*). The coaches will model effective parenting. The goal is to alter the way parents have been responding to the adolescents’ behaviors. How often the skills training group meets depends on the setting.

Phone coaching. The primary therapist is the phone coach for the adolescent. The goal is to provide crisis intervention and to address relationship concerns between adolescent and

therapist (to reduce shame, avoidance, and dropout). DBT therapists strongly encourage the client to call prior to self-harm, to explore different skills to use. The skills training group leader is the phone coach for parents to receive coaching and to promote skills (Miller, Steinberg, & Steinberg, 2011). Parents are encouraged to inform the adolescent about contact with the coach.

Family therapy. Family therapy sessions are used to educate parents about the adolescents' emotional vulnerability. Parents' own emotion dysregulation will also be addressed. Family therapy can help improve the family as a group function in a "more effective, respectful, and loving manner by teaching validation and interpersonal effectiveness skills" (Miller et al., 2007, p. 190).

Walking the Middle Path. This is a new module added to DBT-A to address "common adolescent-family dialectical dilemmas such as excessive leniency versus authoritarian control, normalizing pathological behaviors versus pathologizing normative behaviors, forcing autonomy versus fostering dependence" (Miller et al., 2007, p. 96). The goal is to help improve problem-solving skills so families can find a middle ground between their viewpoints. Another goal is to help the individual move between extremes to find a middle ground that allows for more consistency in behaviors. These goals are practiced through role plays and family homework assignments.

Conclusion

Literature indicates that there are benefits to including parents in therapy with adolescents (Rathus et al., 2015; Feng et al., 2009; Miller et al., 2007). Most of all, it seems more productive and effective in the long run to try to change the family system as opposed to the individual. Mehlum et al. (2016) conclude that DBT-A both in the short term and from a 1-year post-treatment follow-up perspective leads to a reduction in the frequency of DSH. Groves, Backer,

Bosch, and Miller (2012) add that post DBT-A treatment, adolescents exhibited significant improvements in suicidal ideation, emotion dysregulation, and depressive symptoms. “Both patients and parents indicated a high degree of satisfaction with the DBT approach and the progress that the adolescents made during treatment” (p. 70). From a different angle, the results of the study done by Uliaszek et al. (2014) provide support for multifamily DBT skills training group as an add-on to treatment as usual for adolescents with BPD traits.

The purpose of this research project is to determine whether parental inclusion in skills training groups within DBT-A is an effective intervention to help self-harming female adolescents.

Conceptual Framework

This research project uses a systematic review determining whether parental inclusion in skills training groups within DBT-A is an effective method to help self-harming female adolescents. This is important because the number of self-harming adolescent girls is increasing. Therefore, to learn about an effective intervention is crucial.

The social work profession has a responsibility to provide people working with adolescent girls, like school educators, with knowledge around the correlation between family dynamics, emotion dysregulation and DSH. Children growing up in dysfunctional families often carry the symptoms. This is important to know, otherwise, the girls’ behavior may be misinterpreted.

The main theory that guided this review was Bowen's Family System Theory (BFST). Bowen is considered "a pioneer in the area of family study" (p. xiii). BFST explains the benefits of including family systems in treatment and to not just focus on the symptomatic client.

Theoretical Lens

The theoretical lens that will be used to conduct this research is the BFST. It is used to understand how family dynamics can contribute to adolescents' emotion dysregulation and subsequent DSH. BFST is about the ability to see the family as an emotional unit (system) and the symptoms of the individual being an element in the functioning of that unit. Bowen (1966) states: "Every organism influences and is influenced by its' environment" (p. 17). Therefore: "Therapy directed at any family member, not just the symptomatic member, can modify the whole unit" (p. viii). Bowen emphasizes the importance of understanding the relationship system because people are highly vulnerable to falling into the same old emotional patterns. Bowen (1976) considers "emotional illness to be a disorder of the emotional system" (p. 16) and suggests that "the interaction between parents influences the functional state of the family unit" (p. 28). Parents' behavior also tells us the degree of attachment (how tolerant is each for a difference in the other). The development of children can be blocked when the caretaker is not able to allow the child responsibility for self which causes the child to remain attached to the parents. Subsequently, the child establishes a sensitivity to the functional state of each parent and an emotional need for another. Bowen defines this as the unfinished, partial differentiation of self. DSH may be one manifestation of partial differentiation. For example, a controlling parent may have difficulties accepting differences in her/his child and invalidates the child's feelings. Consequently, having no other outlet for difficult emotions the child may start engaging in DSH. Brady (2014) stated earlier that DSH can be a way of 'communicating' emotional concerns which are denied in the family of origin. The emotional need for each other in the family system limits the autonomy of each person and the flexibility of the unit. This makes adapting to changes difficult. For example, conflicts can arise between togetherness and differentiation. "The

more an individual responds to pressures toward togetherness, the more he or she focuses on others and their impact on self" (p. 43). This makes families vulnerable to the development of major life problems. The basic level of differentiation is established early in life; family system therapy can help expand it later in life through a disciplined effort such as guiding personal behavior despite intense anxiety in the family (Bowen, 1966).

Professional Lens

From a professional perspective, educators sometimes see DSH as a behavioral issue and don't see the emotional component. Understanding the correlation between adolescent girls' self-harming behavior, often preceded by emotional dysregulation, in turn often caused by family dysfunction may be the difference between successfully versus unsuccessfully resolving a crisis. To prevent adolescent girls' dysregulated behavior from being misinterpreted and therefore approached as behavioral dysfunction requires educating people who work with the girls every day to prevent more trauma. This could be a task for clinical social workers.

Personal Lens

I am a strong believer in family systems theory. Even though I see the value in diagnosing people through the DSM-5 lens, I find myself approaching cases from a broader perspective, especially when working with children. Many children in the mental health circuit have family dysfunction in common. They carry the symptoms and may be considered the problem without acknowledgement of family influences. This goes against my own personal values. BFST and DBT/DBT-A share the focus on the system and the perspective of emotion dysregulation of a child who struggles with trauma, be it from being hindered in her development or from being overly sensitive to the needs of others.

Methods

This study is a systematic review which determines whether parental inclusion in skills training groups in DBT-A is an effective method to help self-harming female adolescents. Another purpose is to provide knowledge around the correlation between family dysfunction, the meaning of emotional dysregulation and DSH in adolescent girls. An article search of social work databases was completed, and articles were compiled that addressed the effectiveness of parental inclusion in skills training group in DBT-A. Articles were drawn using the following search engines: Social Work Abstracts, SocINDEX with Full Text, PsycINFO, Google Scholar, Family Studies Abstract, Child Development and Adolescent Studies, Academic Search Premier, Expanded Academic ASAP, JSTOR. Terms used to search these databases included: Dialectical Behavior Therapy, self-harm or self-injury or self-destructive behavior or self-mutilation and adolescents, or combinations. Only articles in English, DBT-A, adolescent girls, family or parental inclusion in DBT-A and self-harm (or self-injury or self-mutilation or self-destructive behavior) went through the second screening process. Books were excluded. A total number of 28 articles were eventually selected for a final screening to be included in the systematic review. Articles range from 2006-2016 and both qualitative and quantitative research was included.

Table 1 *Search engine results*

Search Engine	All Articles	First screening	Second Screening
PsycINFO/PsycNet	13	4	4
Child Development and Adolescent Studies	654	9	6
Family Studies Abstracts	309	1	1
Social Work Abstracts	192	2	0
SocINDEX with Full Text	3101	2	0
Google Scholar	3680	34	10
Academic Search Premier	34	16	10
Expanded Academic ASAP	1383	4	1
JSTOR	38737	3	1

Findings

Search results produced a total of sixteen articles that met selection criteria. Included are theoretical articles, literature reviews (comparisons with treatment as usual, empirical outcomes, open studies, quasi-experimental trial, open clinical trial, a qualitative analysis, cross sectional and longitudinal studies, a combined qualitative – quantitative approach, one randomized control trial study utilizing usual care as the control condition and an uncontrolled pre-post treatment study) methodological studies, including: pilot studies, pre-post studies and a descriptive mixed method design study. Themes include: the effect of DBT-A on adolescents and caregivers, pros, and cons of group interventions with and without caregivers, implications for mental health professionals.

Table 2 *Theoretical articles*

Author	Research design	Method	Findings
Neece et al. (2013)	case example	review biosocial theory, emotion regulation, highlight areas of overlap, DBT interventions	inclusion of parents is critical in ensuring that the approach is developmentally sensitive
Ben-Porath (2010)	case examples	review DBT dialectics, biosocial model, validation, highlight applicability to parents who struggle with affect dysregulation	DBT treatment holds out considerable promise as an adjunctive treatment to traditional parent training programs

Table 3 *Literature/systematic reviews*

Author	Research Design	Method	Findings
Arbuthnott, A. E., Lewis, S. P. (2015)	systematic review	NSSI among adolescents and the role of parents, includes 82 articles	parents can play a key role in supporting youth who self-injure
Arthur, R., Salsman, N. L. (2011)	literature review	6 articles, different settings	inclusion of parents promotes generalization of skills and validation
Choate (2012)	literature review	conceptualizing onset and maintenance of NSSI in adolescents and how DBT can be applied	skills training is essential, parent learns skills to provide more effective responses to meet the child's needs
Groves et al. (2012)	literature review	12 studies, various populations, settings, structure, format of treatment	DBT-A may help improve the lives of adolescents and their families
Freeman et al. (2015)	systematic review	six outcome studies published between 2002 and 2015, pre- and posttest comparison design, extended post-treatment follow-up, a comparison group, one randomized control trial study	variations in: mixing definitions of self-harm across studies, diagnostic inclusion/exclusion criteria, utilization of outcome measures, treatment length and intensity for therapeutic change, and adherence to core principles of DBT
MacPherson et al. (2012)	systematic review	summary of DBT literature and outcome research, review of DBT-A and outcome research	inclusion of family members in skills training is beneficial, DBT-A shows promising results
Miller and Smith (2008)	literature review	reviews epidemiological data, existing treatments for adolescents engaging in NSSI, DBT and concludes with a vignette	DBT is a promising treatment for NSSI, decrease of DSH among adolescents receiving TAU plus group therapy

Table 4 *Methodological studies*

Author	Research Design	Method	Findings
Perepletchikova et al. (2011)	pilot study, self-report measures at pre- and post-intervention	11 pre-adolescent children, regular classes, a 6-week DBT skills group, twice a week, without parents	acceptability, feasibility, and efficacy of adapted DBT skills
Fleischhaker et al. (2011)	pilot study, pre-/post-comparison and a one-year follow-up	outpatient, 16 to 24 weeks 12 adolescents plus caregiver	diagnostic criteria decreased, NSSI behavior reduced
Uliaszek et al. (2014)	open pilot trial	psychopathology assessed pre- and posttreatment, 16 weekly sessions, 2 hours, 5 families at a time	support for multifamily DBT skills group as an add-on to treatment as usual
Rathus et al. (2015)	qualitative analysis, Treatment Acceptability Scale, DBT skills-rating scale	assess acceptability of Walking the Middle Path, 50 participants	inclusion of Middle Path leads to improved family functioning
Nelson-Gray et al. (2006)	qualitative study	skills training component of DBT implemented in a group therapy format for outpatient adolescents who met criteria for ODD	Decrease of negative behaviors and increase of positive behaviors, DBT skills training in a nonrestrictive outpatient setting is feasible
Ekdahl, Idvall and Perseius (2014)	descriptive mixed method design study, with a combined qualitative – quantitative approach	child- and adolescent psychiatry unit, 2-years, DBT was implemented as treatment for self-harming patients showing BPD symptoms, adults with a parental relationship to children participated	DBT-FST is a beneficial intervention for SO's
Woodberry and Popenoe (2008)	uncontrolled pre- post treatment design	Adolescent Functioning by Adolescent Self-Report and by Parent Report, Parent Functioning by Parent Self-Report	promising treatment which benefits adolescents with features of BPD and parents, feasible within a community treatment setting

Research Articles

1. Dialectical behavior therapy and suicidal behavior in adolescence: Linking developmental theory and practice.

This theoretical article discusses the application of DBT with adolescents from a developmental perspective. It links Linehan's biosocial theory and the development of emotion regulation and focuses on the interaction of the invalidating parent– child relationship and emotion regulation skills. The article discusses interventions from DBT as they apply to the adolescent, the parent, and the parent– teen dyad. The adolescent-focused components of DBT align well with the developmental psychopathology approach. Parents may benefit from learning basic emotion regulation skills, which are addressed in DBT skills training groups. The inclusion of parent interventions in DBT with adolescents is critical in ensuring that the approach is developmentally sensitive. The case example suggests that approaching suicidal behavior from a developmental perspective and utilizing corresponding DBT-A interventions can result in positive treatment outcomes. Thus, it is critical that interventions aimed at reducing suicidal and self-harm behaviors target the adolescent, parent, and the dyadic relationship (Neece, Berk, & Combs-Ronto, 2013). While this article is theoretical, the tenets of the article are supported by other studies in this review.

2. Dialectical Behavior Therapy applied to Parents Skills Training: Adjunctive Treatment for Parents with Difficulties in Affect Regulation.

This theoretical article describes the applicability of DBT as an adjunctive treatment to parent training programs. Few parent training programs specifically teach parents how to regulate their own negative affect. DBT offers skills training teaching affect regulation. The study illustrates how mental health professionals can help address affect dysregulation in parents.

Mental health professionals can teach them DBT skills. This is particularly important when their child's behavior is the source of emotional arousal. Mental health professionals can psycho-educate the parents, including the biosocial model and the importance of validation. DBT skills such as: acceptance vs change, mindfulness and opposite action can be helpful for parents. The conclusion is that the applicability of DBT holds out considerable promise as an adjunctive treatment to traditional parent training programs (Ben-Porath, 2010).

3. Parents of youth who self-injure: a review of the literature and implications for mental health professionals.

This literature review supports the inclusion of skills training for parents of adolescents who engage in self-harm. The article reviews a total of 82 articles, all peer reviewed. It examines non-suicidal self-injury (NSSI) among children and adolescents, specifically, the role on parents' wellbeing and parenting which can increase NSSI risk. Fifty-three cross sectional and longitudinal studies were reviewed on the risks of self-harm associated with parents in at least one of four categories: youth NSSI risk factors; youth help seeking for NSSI; intervention for youth NSSI; and parent experiences of youth NSSI. Findings from this review include that parents can play a key role in supporting youth who self-injure when provided with education, skills training, and peer support (Arbuthnott & Lewis, 2015).

4. Adapting dialectical behavior therapy to help suicidal adolescents: including the family, other changes increase DBT's efficacy for these patients.

This study reviews evidence that supports the efficacy of DBT-A's "Walking the Middle Path" module. It includes: one nonrandomized trial, where Rathus & Miller (2002) compare patients treated with DBT and patients receiving TAU; one uncontrolled study by Woodberry & Popenoe (2008) examining DBT for suicidal adolescents and their parents in a community

outpatient clinic. Three studies were in residential facilities; one pilot study by Katz et al. (2004) compared patients treated with DBT with patients receiving TAU. Sunseri (2004) used DBT with females and Trupin et al. (2002) taught DBT to staff at a female adolescent juvenile rehabilitation facility. Findings include that the generalization of skills is more likely to occur with families' help. Having family members practice the skills decreases the likelihood that the home environment invalidates the adolescent (Salsman & Arthur, 2011).

5. Counseling Adolescents Who Engage in Nonsuicidal Self-Injury: A Dialectical Behavior Therapy Approach.

This theoretical article presents a model for conceptualizing the onset and maintenance of NSSI in adolescents and how DBT can be applied. DBT addresses intrapersonal and interpersonal vulnerabilities associated with NSSI. Skills training is preferably taught in group format. They are highly structured and meet for 16 weeks, consisting of adolescent and one caregiver. The group format provides an effective way to learn how to communicate needs and wants in relationships; also: the parent learns new skills to help with parenting practice and how to provide more effective responses to meet the child's needs. To enhance DBT effectiveness, family counseling, phone consultation and counselor consultation meetings are added. However, the study found limitations to the feasibility of practicing the whole DBT package; counselors in residential treatment setting are not always able to offer it consistently (Choate, 2012).

6. Review: Dialectical behaviour therapy with adolescents.

This literature review is on the use of DBT-A, using articles published between 1997-2008, including: 2 quasi experimental studies (in/outpatient), 2 pre-post community clinics, 2 pre-post outpatients, 1 pre-post inpatient, 1 pre-post residential, 1 pre-post specialty outpatient, 1 pre-post w/ control group, 1 single case outpatient specialty, 1 pre-post case series outpatient.

Eleven out of 12 studies offered Skills Group Training (SGT), 7 TAU offered SGT, 1 offered SGT but family did not attend. Findings include: DBT-A, including the Skills Group Training, may help improve the lives of adolescents and their families. Findings indicate that DBT-A is a promising treatment for adolescents meeting different diagnostic criteria. After DBT treatment they were hospitalized less frequently. In addition, in the studies conducted it is suggested that DBT treatment may be adapted for use in different settings (Groves et al., 2012).

7. Outpatient Dialectical Behavior Therapy for Adolescents Engaged in Deliberate Self-Harm: Conceptual and Methodological Considerations.

This review of 6 outcome studies published between 2002 and 2015 highlights conceptual and methodological issues in studies related to DBT-A treatment of adolescents engaging in DSH. Four studies utilized a non-control group pre- and posttest comparison design; two included extended post-treatment follow-up and two studies included a comparison group and one randomized control trial study utilizing a usual care as the control condition. Growing evidence supports DBT-A as a viable treatment intervention for self-harming adolescents but studies variate in definitions of self-harm, diagnostic inclusion/exclusion criteria, utilization of outcome measures (in evaluating treatments related to DSH it is critical to consider how self-harm is measured: standardized measures and behavioral observations), treatment length and intensity for therapeutic change (considerable variability in length of DBT-A treatment provided to adolescents with DSH behaviors with a range of 12–24 weeks), and adherence to core principles of DBT (considerable variability regarding use of treatment components and intensity of services provided exists) (Freeman et al., 2015).

8. Dialectical Behavior Therapy for Adolescents: Theory, Treatment Adaptations, and Empirical Outcomes.

This is a systematic review that provides a framework for understanding which behaviors are expected to improve with treatment and why. The study summarizes the adult DBT literature, followed by theoretical underpinnings, adaptations, and outcomes for adolescents. Five open studies and one quasi-experimental trial have examined the efficacy of DBT for adolescents. DBT for different disorders were evaluated via open trials or in case studies or series. Six studies examined implementation of DBT for adolescents in specific settings; five included follow-up data. The adolescents have problems in emotion regulation in common. One adaptation for DBT with adolescents involves the inclusion of family members in skills training to enhance effective parenting and foster family support. Findings from pre–post, uncontrolled, and quasi-experimental studies between 2000-2011 examining DBT for adolescents with a range of psychiatric disorders and problem behaviors in various settings show promising results (MacPherson et al., 2012).

9. Adolescent non-suicidal self-injurious behavior: the latest epidemic to assess and treat.

This study reviews the scope of the problem of NSSI, the efficacy of DBT and it concludes with a clinical vignette. There is little epidemiological research specifically addressing adolescent NSSI (differentiating NSSI from suicidal behaviors). There are only a few randomized controlled trials of therapy for NSSI among adolescent samples and the results are mixed. Research shows that multi-systemic family therapy (MST) resulted in fewer acts of self-harm and a greater reduction of symptoms than treatment as usual over a 1- year follow-up. Some studies have evaluated the effectiveness of group-based interventions. Others have

evaluated the effectiveness of TAU versus TAU plus group therapy for adolescents engaging in DSH. Results indicated that adolescents in the group intervention were less likely to repeat their self-injury. In one quasi-experimental design adolescent DBT was compared to TAU in a 12-week outpatient study. The benefit of the group format is that teens learn in the context of other teens. Parents being exposed to other families struggling with similar issues reduces anxiety and promotes connectedness and support. DBT is a promising treatment for NSSI (Miller & Smith, 2008).

10. Adapting Dialectical Behaviour Therapy for Children: Towards a New Research Agenda for Paediatric Suicidal and Non-Suicidal Self-Injurious Behaviours.

This pilot study describes the modification of DBT for pre-adolescent children, having symptoms of depression, anxiety, and suicidal ideation at baseline. Eleven (8-11 years old) children participated in a 6-week pilot DBT skills group adapted according to developmental level twice a week, without parents and no control group. Self-report measures were administered at pre- and post-intervention. The study indicated initial acceptability, feasibility, and efficacy of the DBT skills training and was measured by the children and their parents. One important finding was that it requires parental reinforcement and involvement in skills practice for the children to be able to use the skills. Parents must learn DBT skills and behavior modification strategies. Parents have indicated that learning DBT skills helps their own emotion regulation (Perepletchikova et al., 2011).

11. Dialectical Behavioral Therapy for Adolescents (DBT-A): a clinical Trial for Patients with suicidal and self-injurious Behavior and Borderline Symptoms with a one-year Follow-up.

This pilot study (open clinical trial) supports the effectiveness of DBT-A. It includes a pre-/post- comparison and a one-year follow-up. The time preceding the start of therapy (two to four weeks), four weeks and one year after the end of the therapy program was measured. It was carried out at Child and Adolescent Psychiatric Outpatient Department in an outpatient setting over a period of 16 to 24 weeks in a German-speaking area. Five adolescents (13-19 years of age) plus one of the parents participated. Findings were a decrease of diagnostic criteria, including NSSI. Assessment by the parents showed an improvement of the quality of life, both during therapy, and in the year following therapy. Symptoms of psychopathology diminished mostly in the year after therapy (Fleischhaker et al., 2011).

12. A Pilot Intervention of Multifamily Dialectical Behavior Group therapy in a Treatment-Seeking Adolescent Population: Effects on Teens and Their Family Members.

This pilot study examines the feasibility, efficacy and the effects on caregivers participating in a dialectical behavior therapy (DBT) skills group program adapted for a multi-family context as an addendum to treatment as usual. A sample of adolescents (13 and 17 years) and at least one caregiver participated in a community outpatient clinic. Each adolescent has an individual therapist. The study includes a pre-, and posttreatment assessment through questionnaire packets. The sessions lasted 16 weeks for 2 hours and five families participated at a time. Paired samples t-tests were used to assess differences between pre- and posttreatment. Findings included significant changes in behavioral symptoms. The results of this pilot study

highlight the importance of interventions at the family level and provide support for multi-family DBT skills group as an add-on to treatment as usual (Uliaszek et al., 2014).

13. Treatment Acceptability Study of Walking the Middle Path, a New DBT Skills Module for Adolescents and their Families.

This study assesses the acceptability of walking the middle path module and which aspects of it were perceived helpful to adolescents and parents. A qualitative analysis was performed regarding participants' evaluations of the module. It includes fifty participants (adolescents and parents/caregivers) recruited from two private and an outpatient adolescent clinic at a hospital. Each site offered DBT and a skills training group including the walking the middle path module. Participants were administered a Treatment Acceptability Scale, DBT skills-rating scale for adolescents and an open-ended, qualitative assessment. Findings support the inclusion of the middle path skills in DBT with adolescents, with validation ranked as the most beneficial and most helpful by both parents and adolescents. Qualitative data support that participation in middle path leads to improved family functioning (Rathus et al., 2015).

14. A modified DBT skills training program for oppositional defiant adolescents: promising preliminary findings.

This article is exploring whether it is feasible to implement a modified skills group component of DBT-A in a group therapy format for 54 non-suicidal outpatient young adolescents (10 to 15 years) who met criteria for oppositional defiant disorder (ODD). They were assigned to one of seven 5–9 member groups for 16 weekly, 2-hour group therapy sessions at the University of North Carolina, with an eighth group conducted at a local public high school. Pre- and post-treatment measures were taken. Parents were informed of the content of the four DBT skills training modules but did not take part in the skills training. Eighty-five percent of the 32

participants were male, 15% were female. Thirty-two youths completed a 16-week program. The treatment was effective in decreasing negative behaviors and increasing positive behaviors, per caregiver report. There was also a reduction in externalizing, internalizing and depressive symptoms. This study demonstrates that DBT skills training is feasible and shows promise in improving the behavior of ODD young adolescents (Nelson-Gray et al., 2006).

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

This is a descriptive mixed method design study in Sweden, where the aim is to describe the significant other's (SO) level of anxiety and depressive symptoms before and after DBT-Family Skills Training (DBT-FST). The SO needs to possess coping strategies to handle everyday life, and to create a non-stressful home environment which has shown to be successful for the recovery of persons with psychiatric illness. DBT-FST is a family program. Studies on DBT-FST show improved well-being and an increase in experiences of mastering the situation. The program educates family members and provides a place where patients and family members can discuss issues. This study describes experiences using a combined qualitative – quantitative approach. The SO's describe how they learned useful strategies for their everyday life which makes it easier to be helpful. High levels of anxiety and depression symptoms can be relieved when having a chance to ask questions, learn new skills and be validated in efforts. The results indicate that DBT-FST is a beneficial intervention for SO's. Life before DBT-FST was a struggle, but after the intervention there was hope for the future. The intervention is beneficial for the SO with a high degree of anxiety- and depressive symptoms (Ekdahl, Idvall & Perseius, 2014).

16. Implementing Dialectical Behavior Therapy with Adolescents and Their Families in a Community Outpatient Clinic.

This uncontrolled pre-post treatment study describes the implementation of multifamily group skills training of DBT with adolescents and families in a community-based outpatient setting between September 1997 and July 2002. It obtains parent and adolescent reports of change. The article describes the adolescent functioning by: Adolescent Self-Report, Adolescent Functioning by Parent Report, Parent Functioning by Parent Self-Report. Adolescents from a range of socioeconomic backgrounds, ages 13 to 18, committed to a 15-week treatment package. Three to seven families were treated at a time. The percentage of adolescents wanting to kill themselves dropped from 32% to 5% and most parents reported a significant reduction in depressive symptoms. Parents provided preliminary evidence that they themselves benefit from DBT treatment. DBT is a promising treatment for adolescents with features of BPD and their families and is feasible within a community treatment setting (Woodberry & Popenoe, 2008).

Discussion

Theoretical articles (1, 2)

The theoretical studies discuss the efficacy of parental inclusion in targeting adolescent DSH. Interventions must target the adolescent, parent, and the dyadic relationship. The DBT-A model provides the group format which shows to be an effective way to learn how to communicate needs and wants in relationships for the adolescent and it teaches the parent skills to provide more effective responses to meet the child's needs. The cycle of invalidation that occurs in some families needs to be reduced. The only way to do that is to include families in skills training groups (Rathus et al., 2015).

By linking DBT-A to developmental theory and practice or adding it to parent training programs, the adolescent's emotion regulation skills will improve and it can also help parents regulate their own affect dysregulation. This could also be a task for mental health professionals. Case examples are provided to explicate how DBT-A is applied clinically.

Literature/systematic reviews (3, 4, 5, 6, 7, 8, 9)

Literature and systematic reviews in this study, with a broad focus on several types of studies, also support parental inclusion in targeting DSH in adolescents. Cross sectional and longitudinal studies show that there is an association between DSH and parents. It can affect parents' wellbeing and parenting, which can, in turn, increase DSH. For that reason, parental inclusion in treatment can be beneficial. Having family members included and practicing the skills decreases the likelihood that the home environment invalidates the adolescent. An invalidating family environment is associated with DSH (Sim et al., (2009).

Teens learn in the skills training group in the context of other teenagers and parents are exposed to other families struggling with similar issues. This often promotes an atmosphere of connectedness and support. Multiple studies have showed its efficacy in trials comparing DBT-A to treatment as usual. The review on the efficacy and acceptability of the Walking the Middle Path module added to DBT-A shows improvement of the interaction and the lives of adolescents and their families.

Methodological studies (10, 11, 12, 13, 14, 15, 16)

The pilot studies affirm the effectiveness of parental inclusion in adolescent DSH. The effects on caregivers participating in a DBT skills group program as an addendum to TAU, emphasizes the importance of interventions at the family level. A pre-post- comparison and a one-year follow-up on the effectiveness of DBT-A shows a decrease of diagnostic criteria and

self-harming behavior. Assessment by the parents shows an improvement of the quality of life, both during therapy, and in the year following. A DBT skills training for affected pre-adolescent children shows that parental reinforcement and involvement in skills practice is required for the children to be able to use them.

Implementing a modified skills group component of DBT-A in a group therapy format was measured pre- and post-intervention. It demonstrated that DBT skills training shows promise in improving the behavior of young adolescents diagnosed with ODD, even though parents did not take part in the skills group.

Bowen (1976) considers "emotional illness to be a disorder of the emotional system" (p. 16). In an uncontrolled pre-post treatment study of the implementation of DBT-A and families in a community-based outpatient setting parents provided preliminary evidence that they themselves benefit from DBT treatment.

Multiple studies of the skills group in DBT-A show to be effective for the significant other (parent). Gaining understanding, acceptance, validation, stop and think and mindfulness training, decreases their level of anxiety and depressive symptoms. A goal of DBT-A is to reduce family interactions that interfere with the family's quality of life (Miller & Smith, 2008).

Strengths

This systematic study includes 16 articles with multiple different study designs, to research whether parental inclusion in skills training groups within DBT-A works as an intervention for adolescent girls engaging in DSH. It provides the reader with a clear overview of information on the prevalence of DSH in adolescent girls, DBT and DBT-A, followed by the conceptual framework and narratives of the research articles. The articles are categorized in the discussion by levels of evidence; starting with articles theoretically supporting DBT-A, followed

by literature reviews that include articles that collect data (qualitative, quantitative, case study, mixed methods) and methodological studies: pilot studies, two pre-post studies and one descriptive mixed method study.

This article also approaches the effectiveness of parental inclusion in the skills group of DBT-A from multiple different angles, such as: the study includes an article on modifying DBT for affected pre-adolescent children, applying DBT as an adjunctive treatment to parent training programs, the effects on caregivers, implementing the skills group in a group therapy format for young adolescents who met criteria for ODD and on the SO's level of anxiety and depressive symptoms. This shows the strength of the model.

Limitations

Limitations of the study include: studies using small sample sizes, or excluding control groups. Some studies lacked comparison groups and random assignments. Freeman et al. (2015) reviewed 6 outcome studies related to DBT-A and adolescents engaging in DSH. They found that studies variate in definitions of self-harm, diagnostic inclusion/exclusion criteria, utilization of outcome measures, treatment length and intensity for therapeutic change and adherence to core principles of DBT.

Groves et al. (2012) reviewed articles published between 1997- 2008 and suggest that future research is needed to determine whether a skills training group alone may be effective for some adolescent populations, because there is so much variability in populations, settings, structure, and format of treatment. However, findings from pre-post, uncontrolled, and quasi-experimental studies between 2000-2011 examining DBT for adolescents with a range of psychiatric disorders and problem behaviors in various settings show promising results

(MacPherson et al., 2012). This can be confusing. Also, there is a lack of randomized control trials to measure the effectiveness of DBT-A.

Implications

Social Work Practice and Policy

DSH among adolescents is increasing, it represents a significant public health concern and it is a strong predictor of attempted and completed suicide (Heilbron & Prinstein, 2008; Brent et al., 2013). The biosocial theory explains that many people engaging in DSH are born with a higher vulnerability to emotion dysregulation. This implies that it “runs in the family”. The present study shows that the skills group component of DBT-A has a high success rate for self-harming adolescent girls and can be a very effective treatment model for families. Family systems learn how to cope and deal with every day stressors and how to validate and support one another. For the program to be most effective, one needs to commit to the whole package.

The MN Department of Human Services provides families with support to care for their children, including out-of-home care. On October 01, 2015, Governor Mark Dayton signed a ceremonial bill celebrating the state's largest increase in mental health funding to date:

Psychiatric Residential Treatment Facilities (PRTF): This new service will support children with very serious mental illnesses. Minnesota has been lacking intensive services for children with the most serious mental illnesses, especially those with aggressive or self-injurious behaviors. As a result, there are currently between 300 to 400 children each year whose needs cannot be met by the current system of care. This new service will offer 150 new beds by July 2018 and an array of services to meet the multiple and

changing needs of children and youth and their families, such as individual therapy, family therapy and medication management. FY16/17: \$6.6 million (mn.gov/dhs).

The Children's Mental Health Department provides case management services which help youth with mental illness and their families get the help they need. This could be the entrance to DBT-A. If clinical social workers familiarize themselves with the contents of the program and encourage families to get involved before an out-of-home-placement becomes a topic it could save the community money and families additional trauma. It would likely decrease the number of out-of-home placements and on a side note, reduce the use of the crisis response service because the DBT program provides a 24-hour phone coach.

In conclusion, money should go to increasing the number of DBT-A programs in MN. As MN Department of Human Resources states: "Stable families are a cornerstone of a strong Minnesota".

Future Research

Scholars conducting future research will have to determine the ideal group size of the skills training component of DBT-A. So far, there has not been any research done on this. This includes both the number of adolescents and caregivers. For example, a study could evaluate different group sizes on the same outcome measure, and determine if some group sizes improve more on outcome measures than others.

One of the articles suggests doing more research on adding a parallel group for parents, to teach them DBT skills so that they could model these skills to their children in the case of the skills group being an addendum to TAU. This would certainly be efficient, knowing that it requires adult modelling for children to generalize the skills. This would require disseminating

knowledge on the DBT-A model through appropriate trainings of mental health and case management staff.

Choate (2012) points out that there can be limitations to the feasibility of practicing the whole DBT package. For example: counselors in residential treatment setting are not always able to offer it consistently. Other factors may come in to play as well, such as: not every family “fits” a group or parents are resistant to commit to a skills training group for reasons of their own. In these cases, it may be beneficial to do more research on using the skills training group component of DBT-A as an addendum on treatment as usual depending on diagnostic criteria. DBT-A turns out to be highly applicable.

Conclusion

DBT-A is beginning to amass evidence as a strong model which is highly adaptable. Findings from pre–post, uncontrolled, and quasi-experimental studies examining DBT for adolescents with a range of psychiatric disorders and problem behaviors in various settings show promising results. The combined adolescent/parent skills training group component is of interest, since most self-harming adolescent girls still live with their parents. Studies show the benefit of the group format when comparing the effectiveness of TAU versus TAU plus group therapy for adolescents engaging in DSH. Results indicated that adolescents in the group intervention were less likely to repeat their self-injury after a group intervention (Miller & Smith, 2008). Having family members practice the skills decreases the likelihood that the home environment keeps invalidating the adolescent.

The study also shows that the skills training group affects parents in a positive way. They often struggle with their own feelings of helplessness and may benefit greatly from psycho-education around the function of DSH. The skills training group teaches skills in a non-

judgmental way, which eventually leads to a better understanding between parents and their children. Therefore, inclusion is important. Another reason inclusion is important is modelling the generalization of skills, especially for the pre-adolescents. DBT-A may very well help improve the lives of adolescents and their families.

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