

# Applications of Dialectical Behavior Therapy to the Treatment of Trauma-Related Problems

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# My Intent

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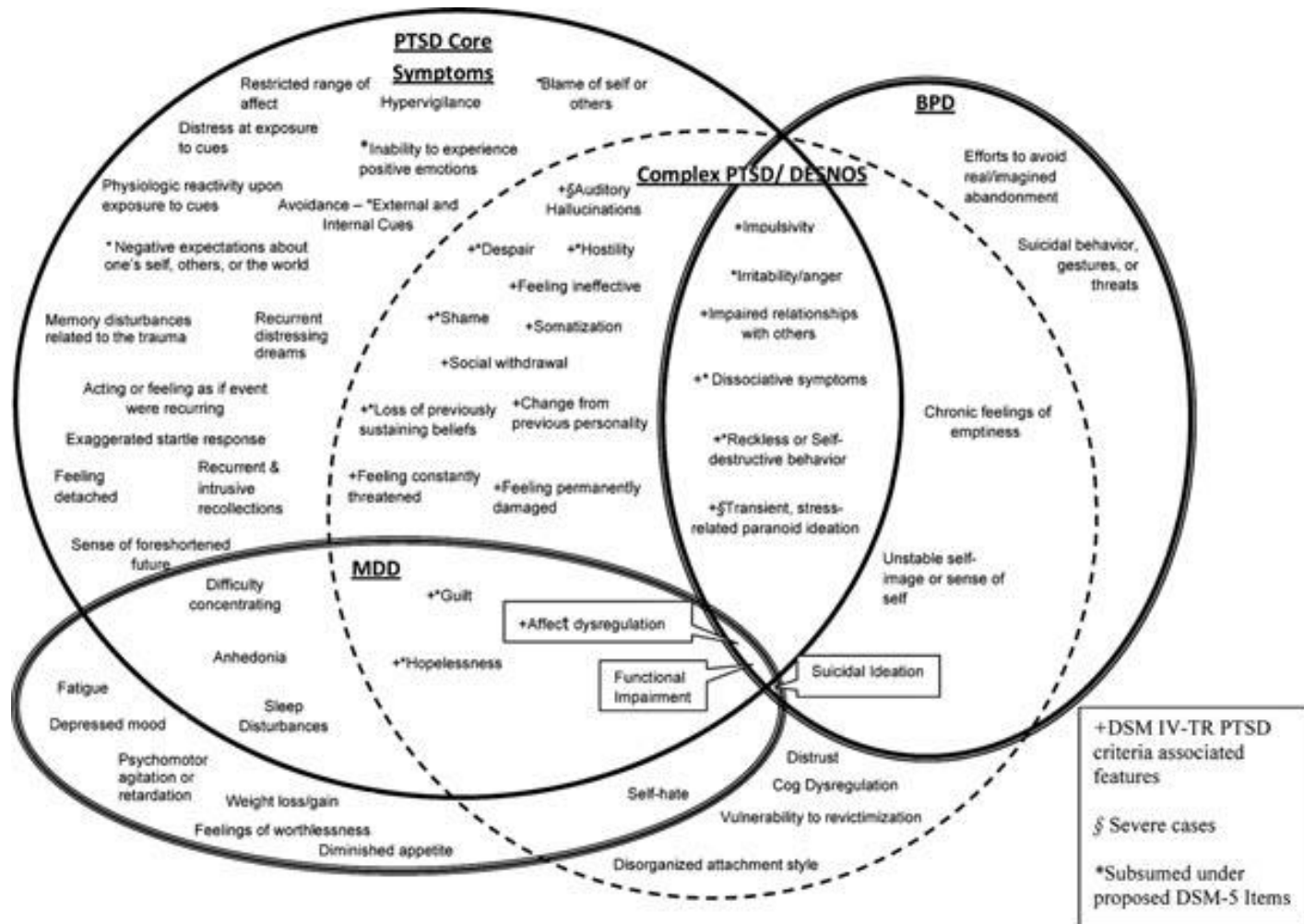
- Provide brief overview of DBT
- Discuss ways in which DBT is relevant to individuals with problems related to traumatic events
- Practice case formulation and treatment planning for individuals with complex presentations
- Introduce a new approach that integrates DBT with Prolonged Exposure

# Existing Treatments for PTSD and Related Problems Have Limitations

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- Despite strong empirical support for trauma-processing therapies (e.g., Prolonged Exposure, Cognitive Processing Therapy), their *reach* is fairly low
- Many people with BPD or other complex presentations are typically excluded from research on trauma-processing therapies
- PE and CPT are based on specific set of problems and case formulation that may not fit many individuals with histories of trauma
- Few well-established treatments exist for the array of problems seen in individuals with histories of repeated traumatic experiences (e.g., “Complex PTSD”)

# What's a clinician to do??



DBT is designed for the multi-problem client with severe emotion dysregulation.

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- Targets a wide-range of problems (that overlap with PTSD and most conceptualizations of “complex PTSD”)
- Based on empirically-supported principles and interventions
- Based on individualized case formulations
- Large and growing empirical support

# DBT Has Strong Research Base

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- DBT has now been evaluated in 30 randomized controlled trials across 19 independent sites in 8 different countries with 12 distinct patient populations
- Adaptations exist for substance use disorders, eating disorders, behavior problems in adolescents, incarcerated individuals with antisocial personality disorder, victims of domestic violence, severe shame, and others
- DBT appears effective for problems related to emotion dysregulation

# Application #1:

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**DBT as stabilization for individuals  
with complex trauma histories  
and/or PTSD**

**(Stage I DBT)**

# DBT Stages and Targets

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<b>TARGET</b>	<b>GOAL</b>
Stage I: Severe Behavioral Dyscontrol	Stability and Behavioral Control
Stage II: Quiet Desperation	Normative Emotional Experiencing & <i>Expression</i> (Fruzzetti)
Stage III: Problems in Living	Ordinary Happiness and Unhappiness
Stage IV: Incompleteness	Capacity for Sustained Joy



# Stage 1 Primary Targets

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## ■ Decrease

- ▶ Life-threatening behaviors
- ▶ Therapy-interfering behaviors
- ▶ Quality-of-life interfering behaviors

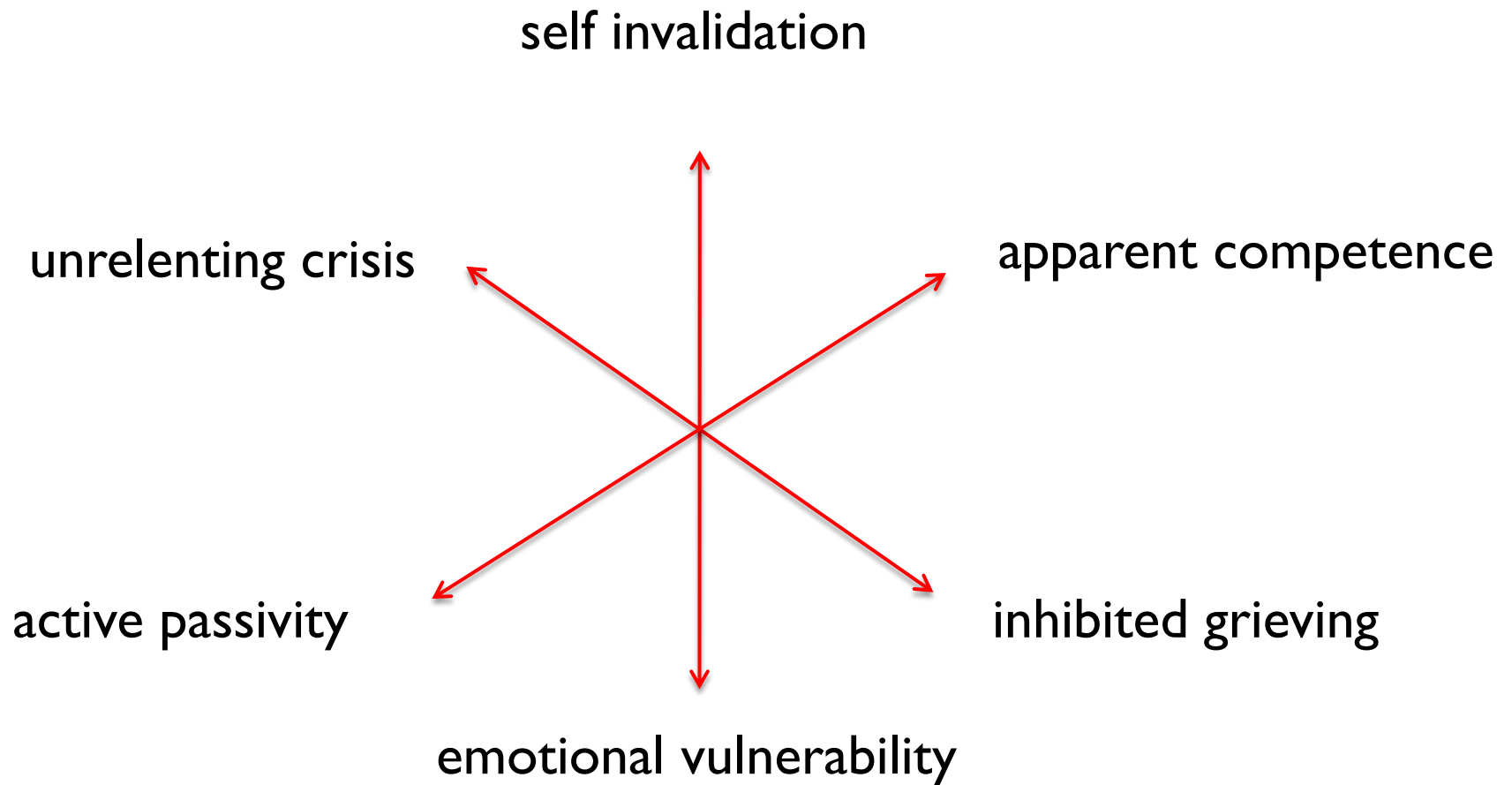
## ■ Increase behavioral skills

- Mindfulness
- Interpersonal Effectiveness
- Emotion Regulation
- Distress Tolerance
- Self-Management



# Stage 1 Secondary Targets

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# Treatment of Trauma-Related Problems in Stage I:

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- Stage I targets treated directly (per standard DBT)
- Stage II targets with a “here and now” approach
  - DBT skills to manage
  - DBT skills to engage in trauma-focused treatment
  - Contingency management and stimulus control

# DBT is a *principal-based* treatment (that includes protocols)

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## ■ 3 main theories guide DBT

- ▶ Behavioral theory
- ▶ Biosocial theory
- ▶ Dialectical theory

## ■ Allows for ideographic case formulation and treatment

- Interventions include standard behavioral interventions, DBT skills, acceptance-based strategies, dialectical strategies

# Fundamental Dialectic

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## CHANGE

Problem-solving

Irreverence

Consultation to  
the patient



## ACCEPTANCE

Validation

Reciprocal  
Communication

Environmental  
Intervention

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DBT is a behavioral therapy that includes validation and dialectical strategies and assumes basic deficits in emotion regulation abilities.



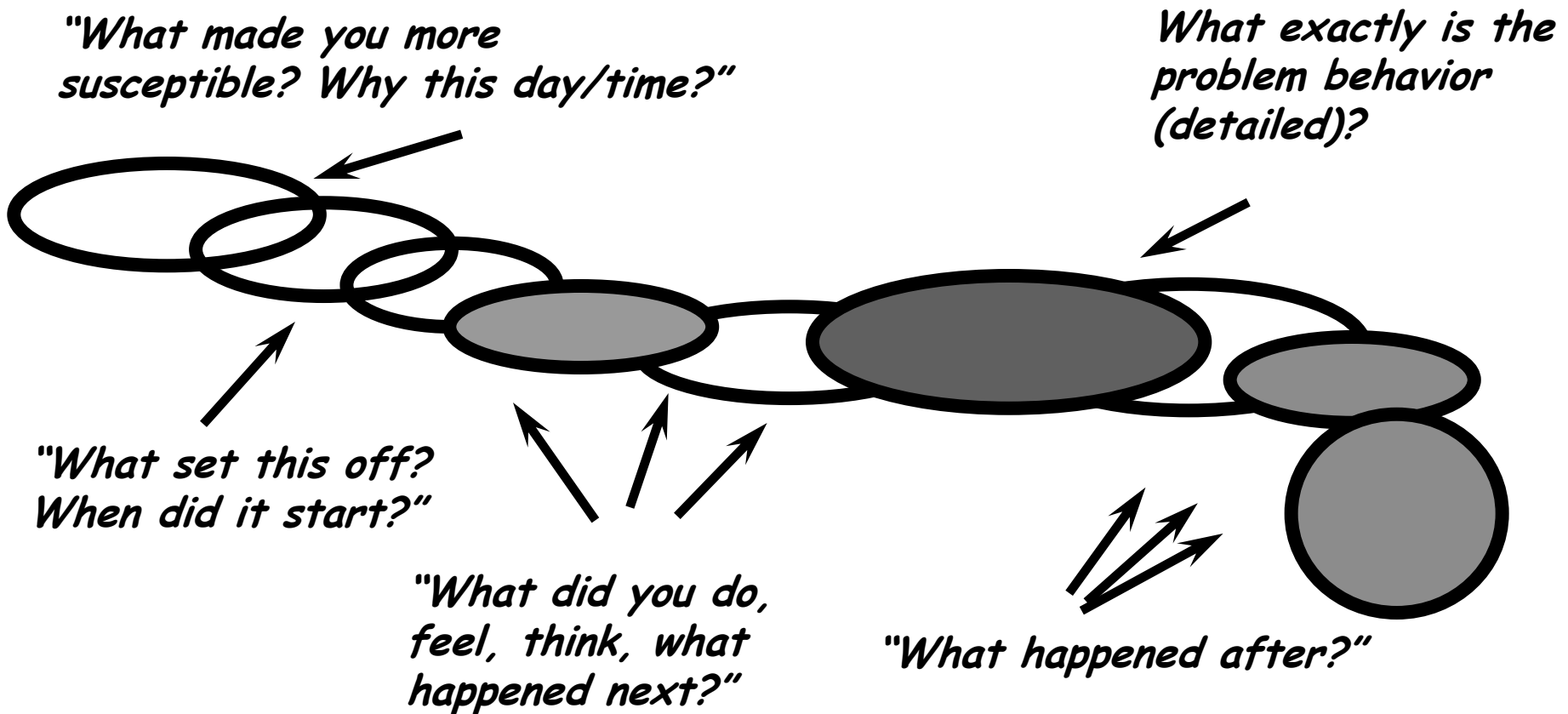
# Case Formulation is Key in DBT

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“a set of hypotheses about the causes, precipitants, and maintaining influences of a person’s difficulties that helps you to translate general treatment protocols into an individualized treatment plan”

# Chain analyses lead to behavioral analyses which inform case formulation.

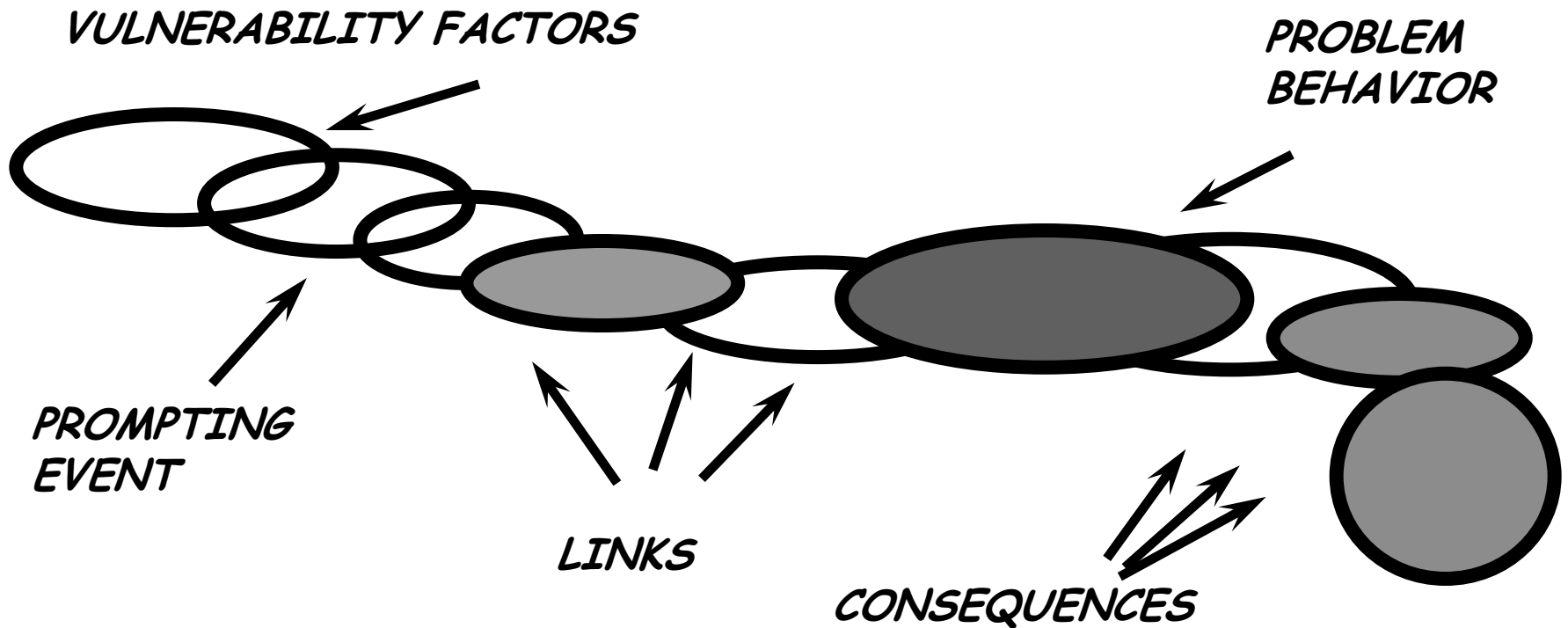
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Look for patterns of controlling variables.

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# Sources of Hypotheses about Controlling Variables

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- ▶ Disorder specific mechanisms from literature (e.g., anxiety sensitivity in panic)
- ▶ Biosocial theory (e.g., emotional dysregulation, dysfunctional behavior as problem-solving)
- ▶ Behavioral principles (e.g., skills deficits, conditioning, etc.)
- ▶ Secondary targets
- ▶ Dialectics

# Interventions in DBT target controlling variables.

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Does the person have the skill?

No: **TEACH SKILLS**

# DBT Skills

<b>Behaviors to Increase</b>	<b>Behaviors to Decrease</b>
<b>Mindfulness</b>	<b>Identity confusion</b> <b>Emptiness</b> <b>Cognitive dysregulation</b> <b>(Dissociative behavior)</b>
<b>Interpersonal Effectiveness</b>	<b>Interpersonal chaos</b> <b>Fears of abandonment</b>
<b>Emotion Regulation</b>	<b>Labile affect</b> <b>Excessive anger (shame, fear...)</b> <b>Emotional avoidance</b>
<b>Distress Tolerance</b>	<b>Impulsivity</b> <b>Suicidal threats</b> <b>Non-suicidal self-injury</b>

# Interventions in DBT target controlling variables.

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Does the person have the skill?

Yes: What's getting in the way?

- Emotions: exposure based procedures, cue-control
- Contingencies: contingency management procedures
- Cognitions: cognitive interventions, wise mind, dialectical reasoning

# Stage I DBT is Effective! But Now What?

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- ▶ Studies show reductions in the Stage I behaviors (self-harm, suicide attempts, psychiatric hospitalizations, substance use, eating disordered behavior, and more).



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Our clients are still in hell: depression, anxiety, substance use, dissociative behavior, anger, PTSD symptoms, poor relationships, eating disordered behavior, etc.

# Application #2:

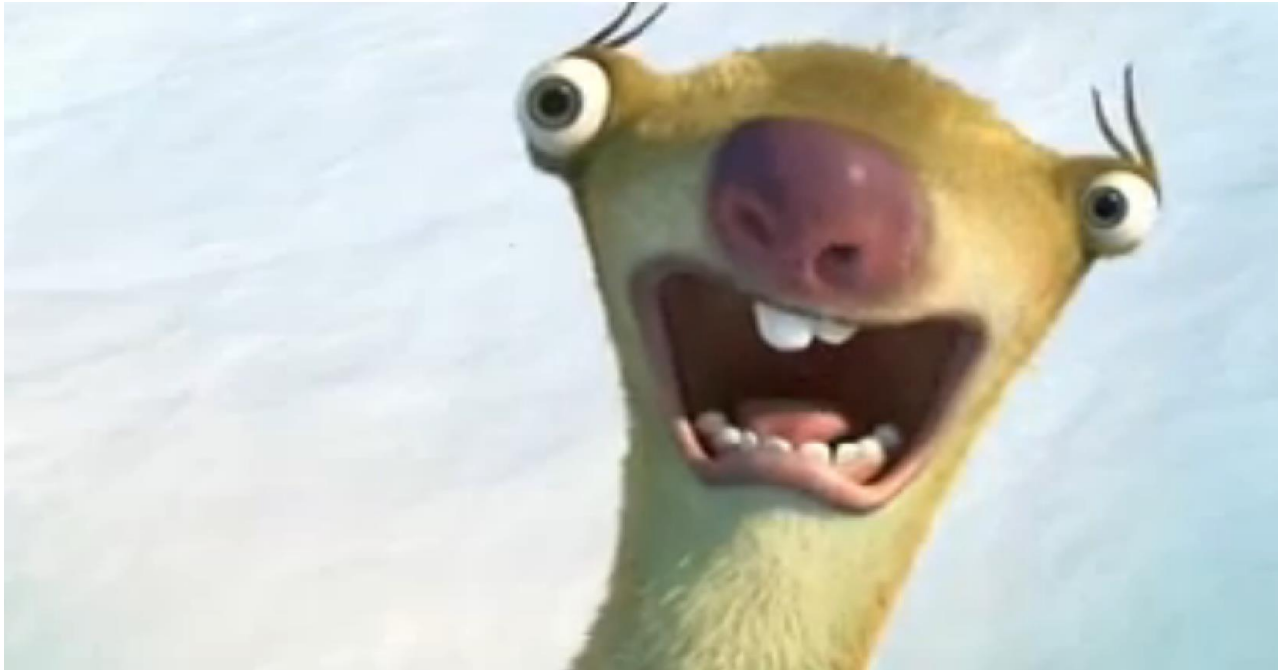
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**DBT as treatment for problems  
related to prolonged and severe  
trauma and invalidation**

(Stage II of DBT)

There is no agreed-upon, defined, or well-evaluated Stage II DBT.

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## Neat Work Being Done with Stage II DBT:

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- ▶ Martin Bohus, MD—Central Institute of Mental Health, Mannheim, Germany
- ▶ Alan Fruzzetti, Ph.D., University of Nevada, Reno
- ▶ Melanie Harned, Ph.D., University of Washington, Seattle

As DBT therapists, we know what we need to know to move forward with Stage II treatment

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“You had the power all along my dear.”

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As in Stage I, Stage II DBT is principle-based and ideographic.

Case formulation is key!

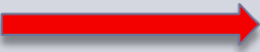
# Case formulation is just as central in Stage II DBT

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- Includes hierarchy of targets (based on client goals, severity of problem, functional relationships between problems)
- Guided by behavioral, biosocial, and dialectical theories
- Interventions pull from DBT skills, behavioral interventions, acceptance-based strategies, dialectical strategies

# Know What You're Treating: Targets for Stage II

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<b>TARGET</b>		<b>GOAL</b>
<i>Quiet Desperation</i>		<i>Normative Emotional Experiencing &amp; Expression</i>
intrusive experiences		mindfulness of current experience
avoidance of emotions*		capacity for emotional experiencing
avoidance of situations/experiences		engagement in meaningful activity
emotion dysregulation		capacity for emotional tolerance
self-invalidation/self-hatred		self-validation/acceptance
other-invalidation/other-hatred		other-validation/acceptance

\*behaviors that function as emotional avoidance

# Behaviors that can function as emotional avoidance (and also increase suffering):

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- ▶ Non-suicidal self-injury
- ▶ Substance use
- ▶ Dissociative behavior
- ▶ Eating disordered behavior
- ▶ Secondary emotions
- ▶ Judgments
- ▶ Intentional suppression
- ▶ Restriction of life activities
- ▶ Facial expressions/body posture
- ▶ Therapy interfering behavior

# When to Start: Considerations for readiness

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## ▶ Client Factors

- ▶ No higher target behavior present
- ▶ Foundation in behavioral skills (especially ability to tolerate, regulate emotions)
- ▶ Connection to therapist
- ▶ Relative stability in living
- ▶ Vulnerabilities to emotions addressed
- ▶ Commitment to Stage II

## ▶ Therapist/Clinic Factors

- ▶ Solid case formulation developed
- ▶ Knowledge/skill in key principles/interventions
- ▶ Sufficient resources to provide adequate treatment
- ▶ Connection to client
- ▶ Consult group

# Where to Start?

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1. Develop thorough list of current problems and diagnoses
2. Select those that can be conceptualized as related to emotion dysregulation/difficulties with emotional experiencing
3. Select those that are creating the most suffering currently and are consistent with client goals
4. Develop thorough and specific behavioral definitions of key problems
5. Consider potential functional relationships between problems (e.g., does the presence of one behavior increase the likelihood of another?)



# Where to Start?

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6. Develop a self-monitoring plan (diary card) for current behaviors and past high risk behaviors
7. Conduct behavioral analyses of target behavior(s)
8. Consider key interventions required
9. Consider your resources
10. Stay open, flexible to new information!

# As in Stage I, Stage II DBT is principle-based and ideographic

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- ▶ **Guided by behavioral theory**
  - ▶ Behavioral analyses remain central
  - ▶ Behavioral theory guides assessment
  - ▶ Behavioral interventions based on assessment
- ▶ **Based on bio-social theory**
  - ▶ Assumes transaction between individual and environment (in development and maintenance of problems)
  - ▶ Attention to role of invalidation (in development and maintenance of problems)
  - ▶ Skills deficits remain a focus
- ▶ **Assumes dialectical world view**
  - ▶ Maintains balance of acceptance and change
  - ▶ Mindfulness skills strengthened, applied to emotions
  - ▶ Promotes dialectical thinking

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Let's put this into action!



# Case Example

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- ▶ “Rhonda” is a 32 year old, divorced female White Army veteran who meets criteria for BPD, PTSD, and alcohol dependence (in remission for 2 months). She has a long-standing history of self-harm behavior, including cutting and burning, but has not engaged in any self-harm for 3 months. She has been in Stage I DBT for the past 6 months.

She has a history of sexual and physical abuse perpetrated by her father and was sexually assaulted in the military.

She has two young children and is currently in a custody battle with her ex-husband.

She reports frequent memories of her sexual assault from the military and sexual abuse as a child. At times this leads to dissociative behavior, including “spacing out” and losing time for up to an hour. She is very isolated—not working and only leaving her home to shop or take her children to school.

# Stage II Targets for Rhonda

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- ▶ **intrusive memories**
  - ▶ sexual assault in the military
  - ▶ childhood sexual abuse
- ▶ **dissociative behavior**
- ▶ **isolated**
  - ▶ not working
  - ▶ rarely leaves home
- ▶ **additional PTSD- and BPD-related problems?**

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What else do you need to know? What's missing?

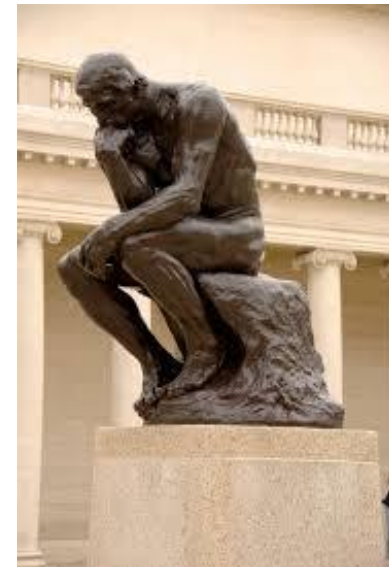
How would you get it?



# Stage II for Rhonda: Considerations

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- ▶ Behavioral descriptions of each problem
- ▶ Current precipitants, maintaining factors
- ▶ Possible relationships between problems
- ▶ Most problematic for Rhonda
- ▶ Priorities for Rhonda
- ▶ Staff/clinic resources



# Zeroing In on Interventions:

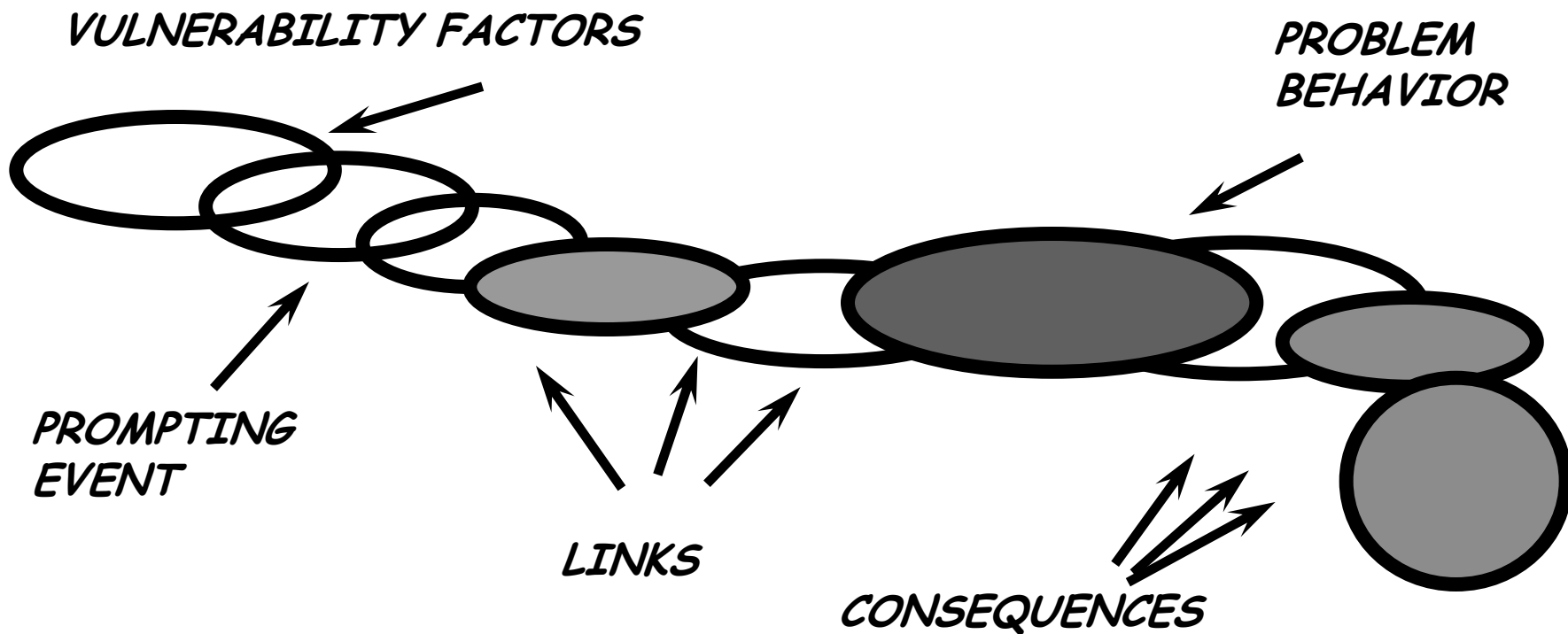
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- ▶ Use diagnostic and self-report measures
- ▶ Self-monitoring: consider how you would modify a diary card to keep track of targets/goals
- ▶ Behavioral analyses remain central
- ▶ Behavioral, biosocial, and dialectical theories guide assessment



Look for patterns of controlling variables.

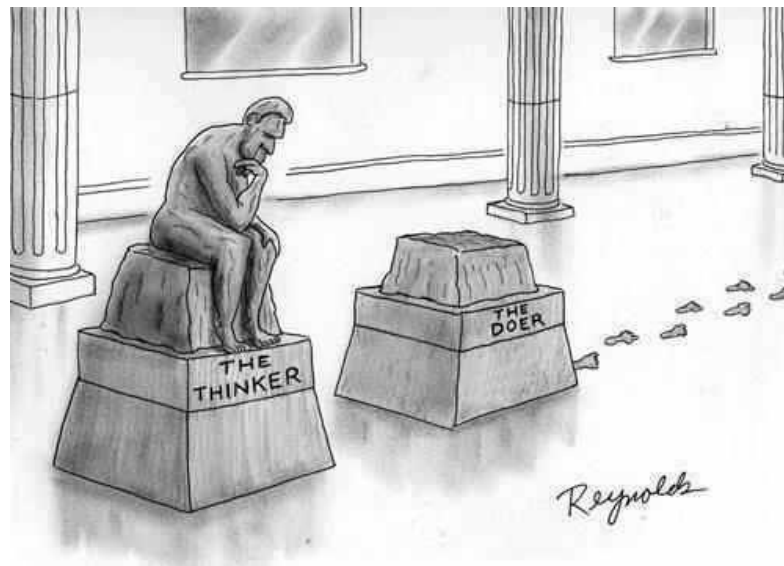
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# Possible Interventions for Rhonda:

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- DBT-PE Protocol (Harned et al.)
- Individualized treatment based on assessment of target behaviors



## Let's do a quick self-check:

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- ▶ What are the four primary maintaining factors we are looking for in our chain analyses (hint: they correspond to learning theory/types of learning)?
- ▶ What are the four primary categories of interventions?



# Key links and interventions from behavioral theory:

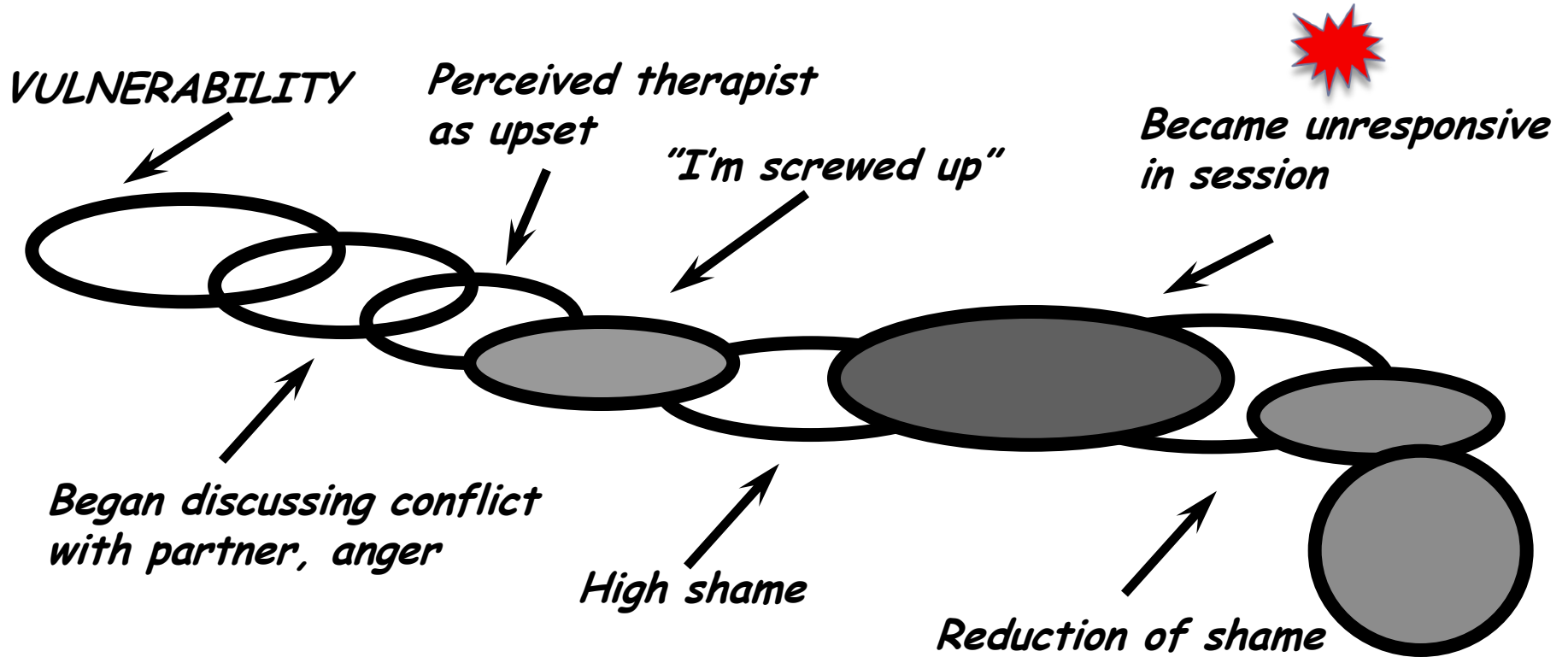
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## Maintaining Factors

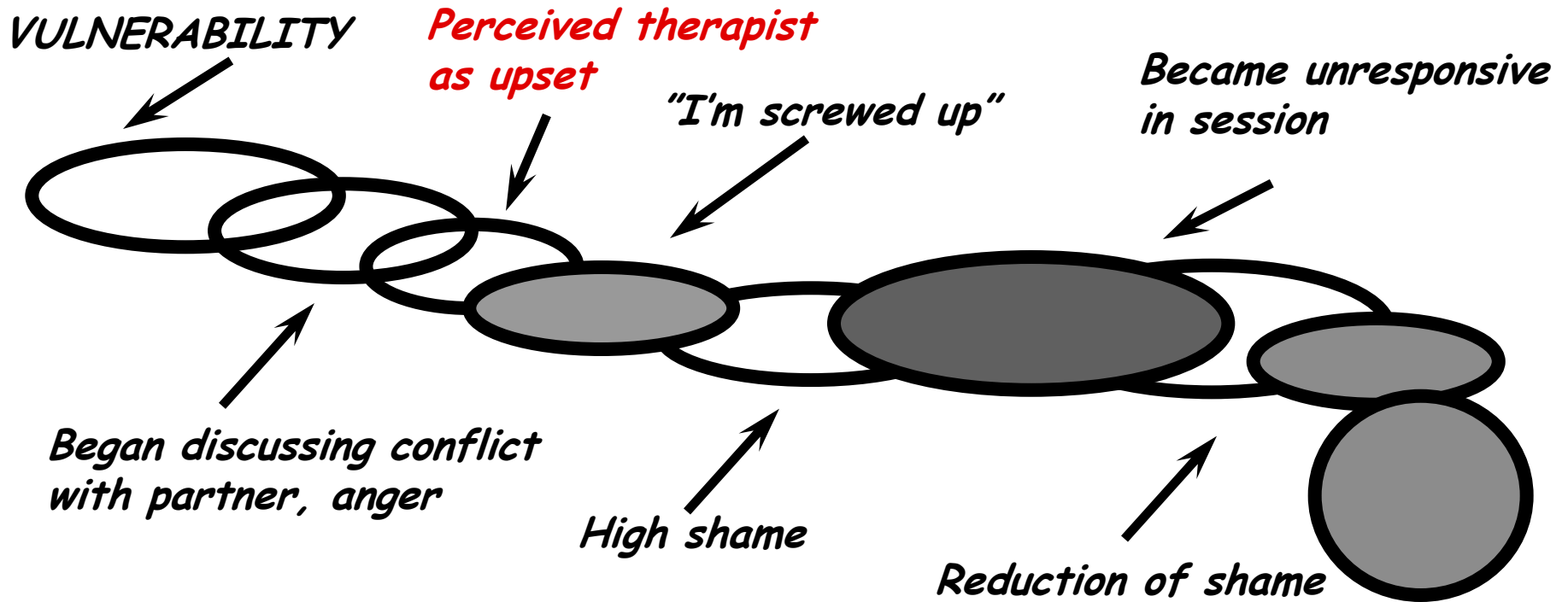
## Interventions

skills deficits	→	skills training
cues in the environment	→	remove cue or exposure
contingencies	→	contingency management
cognitive factors	→	cognitive interventions

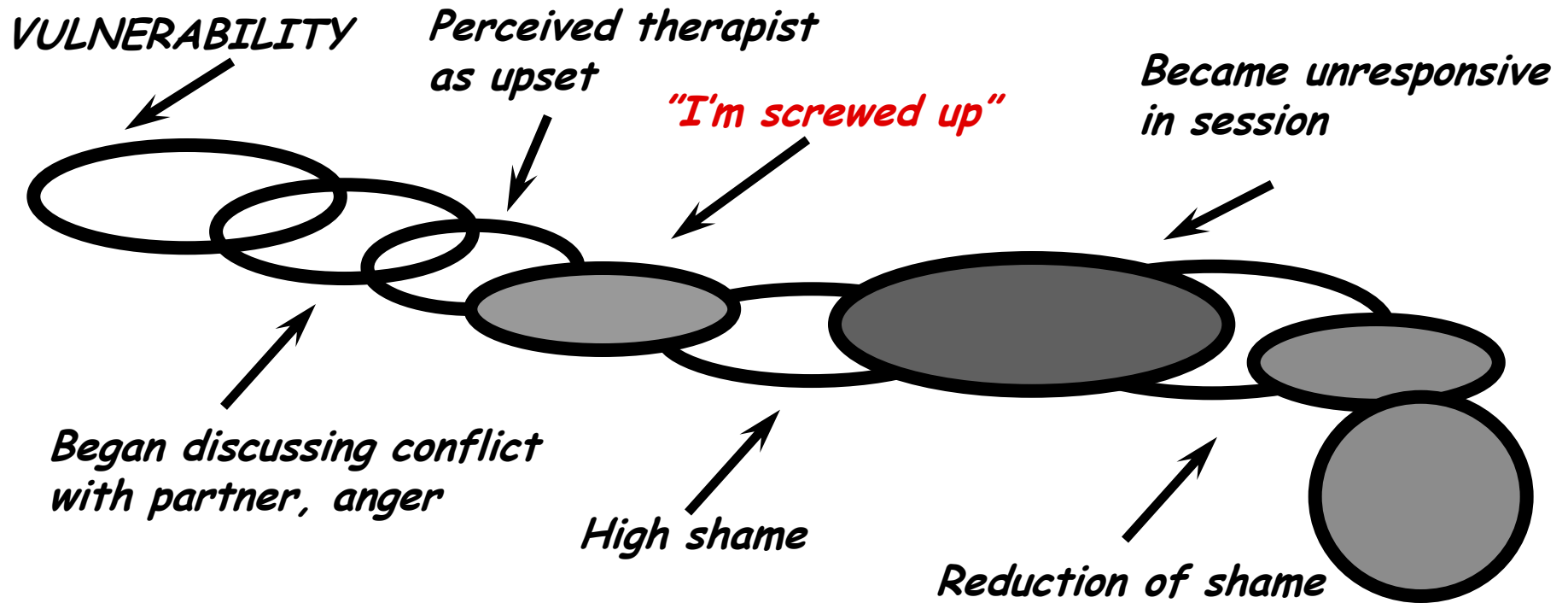
# “Rhonda”



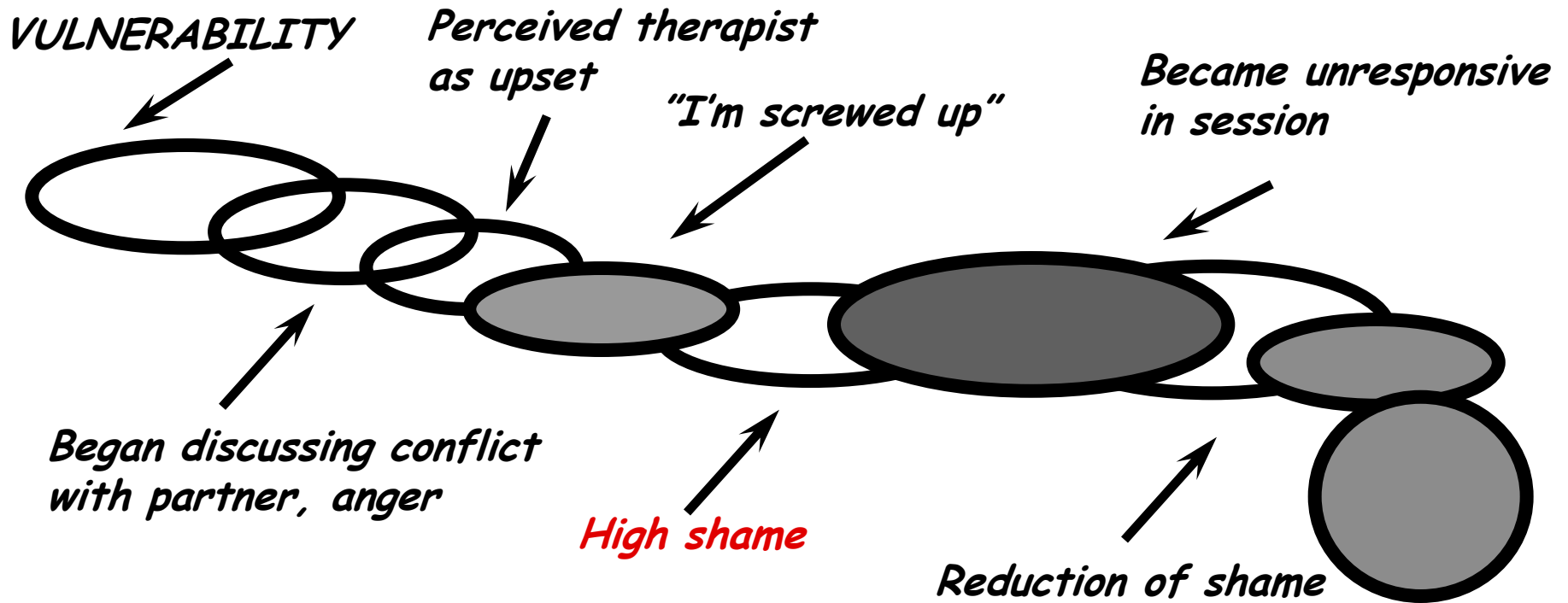
# “Rhonda”



# “Rhonda”

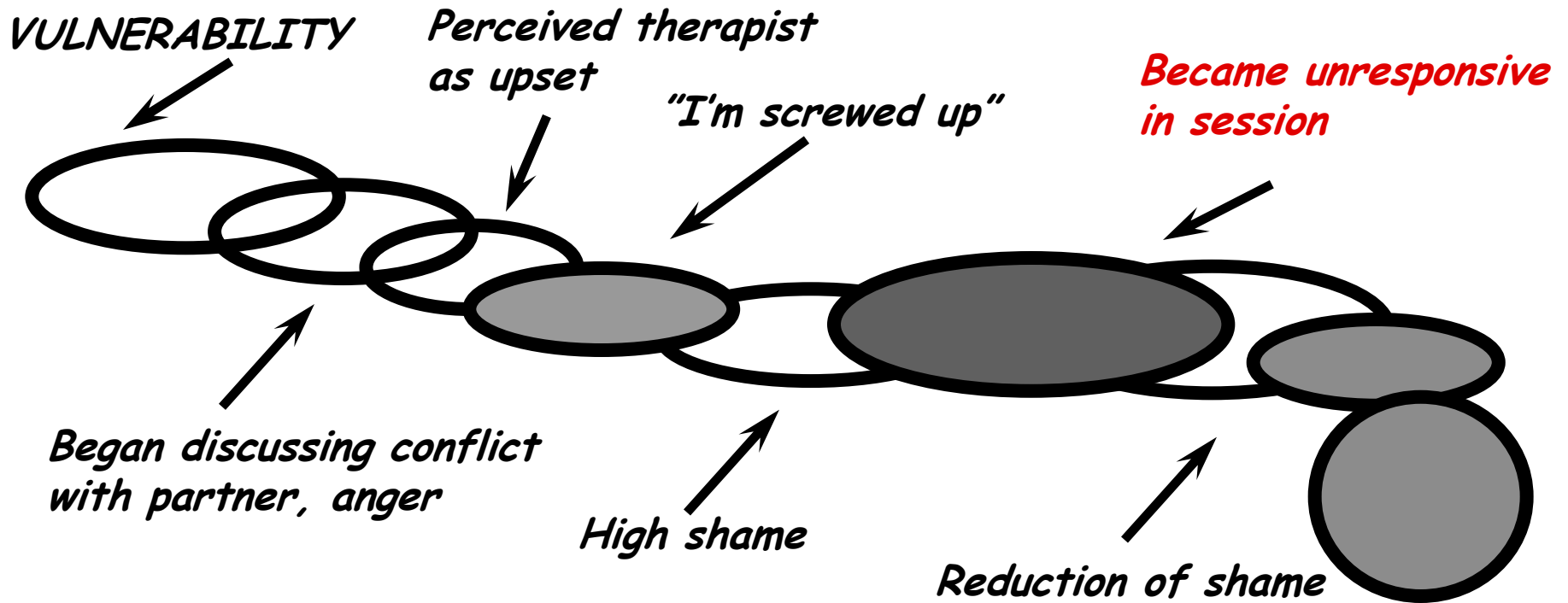


# “Rhonda”

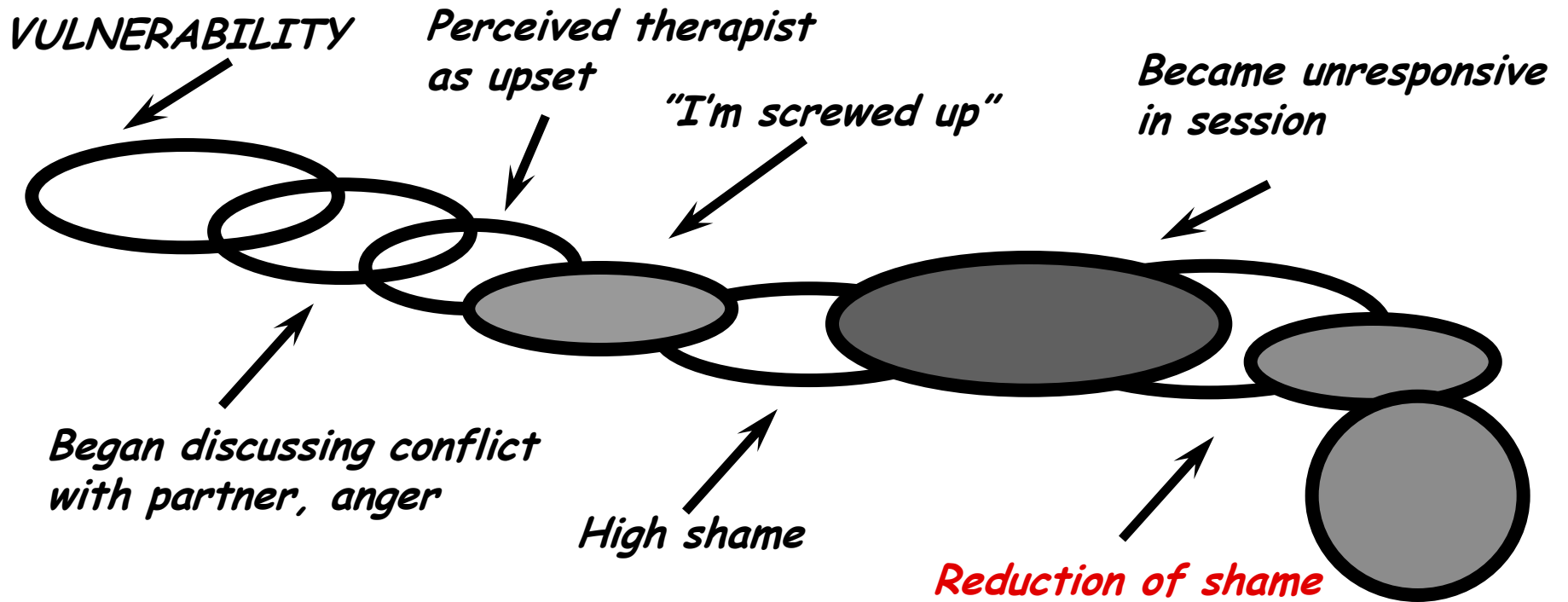




# “Rhonda”



# “Rhonda”



# Possible Interventions for Rhonda

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- ▶ Let's assume key links in chain represent common links to dysfunctional behavior outside of session too.
  - ▶ Need for DBT skills?
  - ▶ Self-invalidation?
  - ▶ Presence of cues, precipitants?
  - ▶ Contingencies?
- ▶ Discuss possible interventions.

# Frequent interventions in Stage II:

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- ▶ Exposure
- ▶ Self-validation
- ▶ Mindfulness of emotions
- ▶ Distress tolerance/willingness

# Steps in “Informal” Exposure:

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- ▶ Orient to the intervention
- ▶ Present cue
- ▶ Block avoidance (including secondary emotions)
- ▶ Opposite action (do it all the way)
- ▶ Allow for corrective information



# Teaching Self-Validation:

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- ▶ Increase awareness of self-invalidation
- ▶ Therapist accurately validates the valid, does not validate the invalid—and is explicit about this
- ▶ Therapist titrates use of validation, pulls for more self-validation
- ▶ Direct teaching of level 4 and level 5 validation
- ▶ Keep the focus on the primary emotion (Fruzzetti)

# Mindfulness in Stage II:

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- ▶ Practice can be longer in duration, more frequent, less guided
- ▶ Increase focus on mindfulness of emotions
- ▶ For individuals with histories of trauma continue focus on awareness of physical sensations.
- ▶ Maintain focus on *non-judgmental* awareness
- ▶ Generate, share practices you like!

# Distress Tolerance in Stage II

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- ▶ **Emphasis on increasing willingness (specifically willingness to have painful emotions)**
  - ▶ Discuss research directly
  - ▶ Look for “I can’t” beliefs
  - ▶ Engender a “bring it on” attitude (or at least “hold gently”); “willingness with your head and your heart”
  - ▶ Mindfulness of physical discomfort as practice
- ▶ **Emphasis on radical acceptance (of current and past experiences)**



# Modes of Treatment

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- ▶ Base this on your case formulation
- ▶ Consider your resources
- ▶ Maintain a consult group!

# Application #3:

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## Treatment of PTSD among individuals with severe emotion dysregulation

(DBT-PE Protocol for PTSD;  
Harned, Linehan, et al.)

# Melanie Harned, Ph.D.: DBT-PE

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- ▶ For treatment of PTSD among individuals with BPD/severe emotion dysregulation
- ▶ PTSD viewed as quality of life interfering behavior
- ▶ Based on PE for PTSD (Foa et al.)
- ▶ Clients remain in standard DBT and have additional 90” weekly sessions of PE



# Readiness criteria for DBT-PE protocol

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- Not at imminent risk for suicide
- No life threatening behavior for 2 months
- Ability to control life threatening behaviors when in the presence of cues for those behaviors
- No serious therapy interfering behavior
- PTSD is highest priority target
- Ability and willingness to experience intense emotions without escaping

# Unique Features of DBT-PE Protocol

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- ▶ Emphasis on commitment to no life threatening behaviors and working on behaviors that could interfere with exposure
- ▶ Utilization of Post-Exposure Skills Plan
- ▶ Common Reactions to Trauma include behaviors related to BPD
- ▶ Imaginal exposure also targets experiences of “traumatic invalidation”
- ▶ In vivo hierarchy includes behaviors that evoke unjustified shame
- ▶ Exposure Recording Form includes pre and post urges to commit suicide, self-injure, quit therapy, use substances, state dissociation, levels of specific emotions and radical acceptance

# Unique Features of DBT-PE Protocol

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- ▶ Includes more strategies for managing over-engagement and dissociation
- ▶ DBT skills used to “up-regulate” emotions for under-engagement
- ▶ Continued use of DBT strategies (validation, dialectical, etc.)
- ▶ More direct cognitive interventions

# Open Trial of DBT PE Protocol (N=13)

(Harned, Korlund, Foa, Linehan, 2012)

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- ▶ Significant reductions in PTSD
- ▶ Majority no longer met criteria for PTSD
- ▶ No evidence of worsening of suicidal or self-injurious behavior, PTSD, treatment drop-out, or use of crisis resources
- ▶ Highly acceptable to clients

# Randomized Controlled Trial, DBT (9)vs. DBT-PE (17); (Harned, Korslund, & Linehan, 2015)

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- ▶ Treatment expectancies, satisfaction, and completion did not differ between conditions
- ▶ Those receiving DBT-PE had greater reductions in PTSD and doubled remission rates (80% v. 40%)
- ▶ Those who completed DBT-PE were 2.4 times less likely to attempt suicide and 1.5 times less likely to self-injure
- ▶ DBT-PE lead to greater improvements on all secondary outcomes measured: dissociation, trauma-related guilt cognitions, shame, anxiety, depression, and global functioning
- ▶ Effect sizes for all measures were strong for DBT-PE



# Next Steps:

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- ▶ Obtain formal training in exposure
- ▶ Consider training in additional (compatible) approaches that address the targets and approach in Stage II
  - ▶ Compassion Focused Therapy
  - ▶ Emotion Focused Therapy
  - ▶ Functional Analytic Psychotherapy
  - ▶ Acceptance and Commitment Therapy
  - ▶ Mindfulness
- ▶ Have a team meeting
  - ▶ Treatment needs in your clinic
  - ▶ Resources available/needed
  - ▶ Plan how you will start
- ▶ Evaluate the impact of what you do!!



# References:

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