

Advanced Treatment Techniques & Targets in Dialectical Behavior Therapy: Emerging Best Clinical Practices for DBT-Trauma Care & Co-Occurring Complex Presentations

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Executive Director of The Wise Mind DBT & CBT Center in Delafield, Wisconsin
FOR THE 16th ANNUAL MENTAL HEALTH AND SUBSTANCE USE RECOVERY TRAINING CONFERENCE
THRIVING IN RECOVERY: SUPPORTING OURSELVES AND OTHERS IN THE JOURNEY
OCTOBER 29, 2020 8:00-9:30 AM VIRTUAL VIA ZOOM

1

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Lisa Herpolsheimer, LCSW, DBT-C, CCTP-I

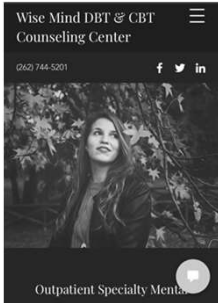
A Brief Introduction to Our Practice and Lisa's Clinical Training and Experience

Lisa is the creator and Executive Director of:

The Wise Mind DBT & CBT Center
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DBT-ADHERENT INDIVIDUAL, FAMILY AND SKILLS GROUPS. WE ALSO PROVIDE CBT FOR TRAUMA CARE AND DBT-INFORMED TRAUMA THERAPY FOR ADOLESCENTS AND ADULTS.

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2

2



Learning Objectives and Outline

1. Learn and understand the latest research in trauma therapy specialized to individuals with emotional sensitivity and multi-complex problems; and the limitations of therapy for PTSD with individuals with co-occurring PTSD who are emotionally dysregulated and engaged in DBT treatment.
2. Build Clinical Skills for addressing the needs of adults and teens enrolled in DBT programs with co-occurring trauma and severe behavioral dysregulation including high-risk self-destructive behaviors.
3. Engage in a Clinical Case Formulation through collaborative review of a hypothetical case.
4. Brief overview of the Linehan DBT-Treatment Model will be briefly reviewed
5. DBT Primary and Secondary Treatment Targets for organizing treatment and making decisions
6. Learn about the DBT-PE (DBT Prolonged Exposure Concurrent Treatment Model for PTSD) as defined by Melanie Harned, PhD and her colleagues, researched and endorsed as safe treatment for DBT participants with significant PTSD that typically would not have good access to PTSD care because of their complex problems and safety concerns.

Key research and Concepts from: Marsha Linehan, Ph.D., Melanie Harned, Ph.D., and colleagues. Major supporters of DBT & DBT-T research development included the Univ. of Washington, The Dept of V.A. Affairs and The NIMH.

3

3

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1. DBT is designed for the multi-problem client with severe emotional dysregulation and behavioral dysregulation
2. Targets a wide-range of problems (that overlap with PTSD and most conceptualizations of "complex PTSD")
1. DBT is Based on empirically-supported principles and interventions
2. DBT is a "Principle-Based" treatment based on individualized case formulations
4. DBT, including DBT-PE has Large and growing empirical support

Amy W. Wagner, Ph.D. Portland VA Medical Center

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Case Formulation and Treatment Structure in DBT

- DBT is structured with stages of treatment and a hierarchy of targets
- DBT Guided by behavioral, biosocial, and dialectical theories
- Interventions include standard behavioral interventions, DBT skills, acceptance-based strategies, and dialectical strategies

Marsha Linehan, PhD, Creator of DBT; Melanie Harned, PhD., Lead Creator of DBT-PE in collaboration with Dr. Linehan.

5

5

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DBT Balances:

Skills Acquisition: teaching new behaviors

vs.

Validating and Reinforcing existing adaptive behaviors

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Determining the Level of Disorder

Domain	Definition
Imminent Threat	The presence of behaviors that create a high risk of imminent death or injury
Disability	The inability to fulfill important societal and/or social roles
Complexity	The number of co-occurring mental disorders and problem behaviors
Severity	The frequency and intensity of psychological and functional problems
Pervasiveness	The degree to which problems are limited to a specific context versus widespread

Linehan, 1999

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Primary Behavioral Targets (2)

- Decreasing Behaviors That Interfere with Quality of Life
- Increasing Behavioral Skills
 - Core Mindfulness Skills
 - Distress Tolerance Skills
 - Emotion Regulation Skills
 - Interpersonal Effectiveness Skills
 - Self-Management Skills
- Decreasing Behaviors Related to Posttraumatic Stress

The Impact of PTSD in BPD

- 30-50% of individuals with BPD also have PTSD (e.g., Harned et al., 2010; Pappas et al., 2010; Zanetti et al., 2006)
- PTSD is associated with greater impairment:
 - Suicidal and self-injurious behavior
 - Depression
 - Anxiety
 - Poorer physical health
 - Poorer global functioning

(e.g., Harned et al., 2010; Zinbarg et al., 2003; Sudhan et al., 2006; Ruzich et al., 2007)


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11

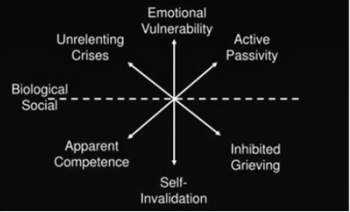
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Common Behavioral Patterns: "Dialectical Dilemmas"



Emotional Vulnerability

Active Passivity

Inhibited Grieving

Self-Invalidation

Apparent Competence


Unrelenting Crises

Biological Social

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DBT Secondary Behavior Treatment Targets - Handouts & Worksheets

* A key point about the following pattern is that the dissociation of the extreme points on each behavior dimension creates that individuals swing back and forth between poles.

Active Passivity

The tendency to appear active but actually be passive and to not be assertive in seeking help or resources & when it is needed for self and others.

Apparent Competence

The tendency to appear competent but actually lack the skills and ability to do so.

Emotional Vulnerability

High sensitivity to emotional distress, especially negative affect, and a tendency to be overwhelmed by it.

Self-Invalidation


Adopting perceptions of the self that are unduly harsh, self-critical, and acknowledging one's strengths and abilities when self, others, and/or situations.

Unrelenting Crises

Exaggerated, unrelenting, and frequent crises, especially negative affect, and a tendency to be overwhelmed by it.

Inhibited Grieving

A pattern of negative emotions and behaviors that are inhibitory to fully experiencing and processing one's emotional pain.



Emotional Vulnerability

Unrelenting Crises

Inhibited Grieving

Self-Invalidation

Apparent Competence


Active Passivity

Biological Social

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DBT Secondary Behavior Treatment Targets - Handouts & Worksheets

Treatment Subtleties

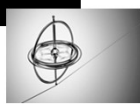
	Active Passivity	Emotional Vulnerability	Unrelenting Crises
Emotional Vulnerability	• High sensitivity to emotional distress, especially negative affect, and a tendency to be overwhelmed by it.	• High sensitivity to emotional distress, especially negative affect, and a tendency to be overwhelmed by it.	• High sensitivity to emotional distress, especially negative affect, and a tendency to be overwhelmed by it.
Self-Invalidation	• Adopting perceptions of the self that are unduly harsh, self-critical, and acknowledging one's strengths and abilities when self, others, and/or situations.	• Adopting perceptions of the self that are unduly harsh, self-critical, and acknowledging one's strengths and abilities when self, others, and/or situations.	• Adopting perceptions of the self that are unduly harsh, self-critical, and acknowledging one's strengths and abilities when self, others, and/or situations.
Apparent Competence	• The tendency to appear competent but actually lack the skills and ability to do so.	• The tendency to appear competent but actually lack the skills and ability to do so.	• The tendency to appear competent but actually lack the skills and ability to do so.
Active Passivity	• The tendency to appear active but actually be passive and to not be assertive in seeking help or resources & when it is needed for self and others.	• The tendency to appear active but actually be passive and to not be assertive in seeking help or resources & when it is needed for self and others.	• The tendency to appear active but actually be passive and to not be assertive in seeking help or resources & when it is needed for self and others.

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15

Every time you are tempted to react in the same old way, ask yourself if you want to be a prisoner of the past or a pioneer of the future. - marcandangel



DBT Secondary Behavior Treatment Targets: Readings & Worksheets

Target	Definition	Warning Signs
Self-Harm The tendency to engage in self-harm, which is defined as self-inflicted physical damage.	High amounts of suicidal ideation, thoughts of self-harm, or actual self-harm.	Excessive suicidal ideation, thoughts of self-harm, or actual self-harm.
Substance Abuse The use of drugs or alcohol to cope with emotional pain.	Increased use of drugs or alcohol to cope with emotional pain.	Increased use of drugs or alcohol to cope with emotional pain.
Impulsivity The tendency to act on urges or impulses without considering the consequences.	Engaging in high-risk activities, such as reckless driving or unprotected sex.	Engaging in high-risk activities, such as reckless driving or unprotected sex.
Emotional Lability The tendency to experience extreme emotional reactions to relatively minor events.	Experiencing intense emotional reactions, such as anger, sadness, or anxiety.	Experiencing intense emotional reactions, such as anger, sadness, or anxiety.


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DBT Diary Card



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Typical Trauma-related Symptoms

- Dissociation
- Flashbacks
- Nightmares
- Hyper-vigilance
- Terror
- Anxiety
- Pejorative auditory hallucinations
- Difficulty w/problem solving
- Numbness
- Depression
- Substance abuse
- Self-injury
- Eating problems
- Poor judgment and continued cycle of victimization
- Aggression

What we want you to understand is that these "symptoms" are not signs of pathology - rather, they are survival strategies that have helped them cope with terrible pain and challenges.

The key is learn how the behavior developed and teach new coping strategies.



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'Emotions and thoughts and sensations, they come and go. What is really 'here' is you. Everything else is a tourist. Everything else is coming and going. You are the witness of the coming and going. Once you know that you are not the thing which is coming and going, peace will prevail inside your mind and heart.'

~ Mooji

Primary emotion

- Inaccurate emotional response—provides misleading info
- Fails to change in response to changing environment
- e.g., "My life is over"

Adaptive

- Accurate emotional response—provides vital info about the significance of events
- Prompts rapid response and action readiness
- e.g., "I'm afraid of being alone"

Maladaptive

- No organized strategy to cope with emotions
- Continue to experience, while blocking primary emotion
- Fuelling maladaptive behaviors
- e.g., "I hate him/her so much that I will call right now to tell him/her"

Adaptive

- Organized strategy to cope with emotions
- Integrates primary emotion
- Balance between reason and emotion
- e.g., "I know that calling him/her will trigger my anger if I hear his/her voice"

Secondary emotion

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Healthy Perspectives on Emotion

- **Emotions are neither good or bad, right or wrong.** Feelings just ARE. They exist. It is not helpful to judge your emotions.
- **There is a difference between having an emotion and doing something or acting on the emotion.**
- **Emotions don't last forever.** No matter what you're feeling, eventually, it will lift and another emotion will take it's place.
- **When a strong emotion comes, you do not have to act on your feeling.** All you need to do is recognize the emotion and feel it.
- **Emotions are not facts.** When emotions are very powerful they feel just like "the truth".
- **You cannot get rid of emotions** because they serve important survival functions. Be willing to radically accept your emotions as they arise.

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Dis dissociative disorders are linked to repeated suicide attempts and self harm

- 67% make repeated suicide attempts
- 42% have a history of self harm

Childhood maltreatment, and childhood sexual abuse in particular, are associated with an increased risk of suicidal and self injurious behavior

source: 2011-D Guidelines for Treating DID in Adults (2011), including Finkelhor, Browne, & Lysachek, 2009; Peterson et al., 1986; Koss & Norten, 1987

© TraumaAndDissociation, 2013
www.dissociative-identity-disorder.net/about-dissociative-disorders

Dis dissociative disorders include:

- Dissociative amnesia (includes fugue)
- Derealization disorder (includes depersonalization)
- Other specified dissociative disorder
- Dissociative identity disorder

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Healthy Brain
The PFC (part of the brain's executive control system) is the seat of our rational thinking, planning, and decision-making. It helps us regulate our emotions and impulses, and it's involved in social interactions and relationships. In a healthy brain, the PFC is highly active and helps us think clearly and make good decisions.

An Abused Brain
The PFC (part of the brain's executive control system) is the seat of our rational thinking, planning, and decision-making. In a brain that has been abused, the PFC is less active, which means it's not working as well as it should. This can lead to problems with thinking clearly, making good decisions, and regulating emotions. The amygdala, which is involved in processing emotions, is more active in an abused brain, which can lead to increased fear and anxiety.

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THE TRAUMA BRAIN

- Obsessive desire to be chosen by new romantic partners without any awareness of how YOU + your body feels about the connection
- Chronic social anxiety about how new people will perceive you
- A need for consistent distraction from the present moment through substance abuse, social media scrolling, love/sex, or chronic daydreaming
- Ego stories of self judgement + comparison
- A lack of self trust that leads to procrastination + self sabotage shame cycles

PSYCHOLOGICAL INJURY
HOW DOES YOUR BRAIN CHANGE WITH PTSD?

HIPPOCAMPUS SHRINKS
THIS AREA HELPS US DISTINGUISH BETWEEN PAST AND PRESENT MEMORIES

INCREASED ACTIVITY IN THE AMYGDALA
HELPS US PROCESS EMOTIONS AND IS ALSO LINKED TO FEAR RESPONSES

VENTROMEDIAL PREFRONTAL CORTIX SHRINKS
THIS REGION REGULATES NEGATIVE EMOTIONS THAT OCCUR WHEN CONFRONTED WITH SPECIFIC STIMULI

THESE CHANGES IN BRAIN CHEMISTRY ARE THE REASONS WHY ONLY TREATMENTS SUCH AS EMDR AND CBT CAN FULLY REVERSE THE EFFECTS OF PTSD.

psd.k
www.psduk.org

Key research and Concepts from: Marsha Linehan, Ph.D., Melanie Harned, Ph.D., and colleagues. Major supporters of DBT & DBT-T research development included the Univ. of Washington, The Dept of V.A. Affairs and The NIMH.

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BEING STUCK ON FIGHT OR FLIGHT

NORMAL RANGE AND BEHAVIOR
Arousal + Activation → Sympathetic → Relaxation → Parasympathetic

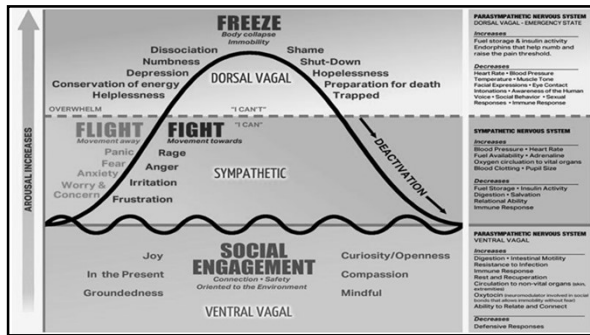
"STUCK ON"
Arousal + Activation → Sympathetic → Relaxation → Parasympathetic

"STUCK ON" SYMPTOMS

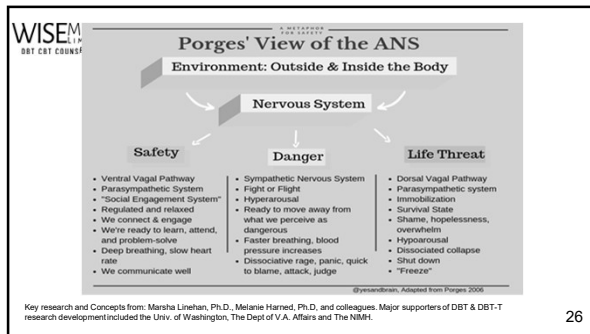
- Anxiety
- Panic
- Insomnia
- Exaggerated Startle
- Hypervigilance
- Digestive Problems
- Chronic Pain
- Hyperactivity

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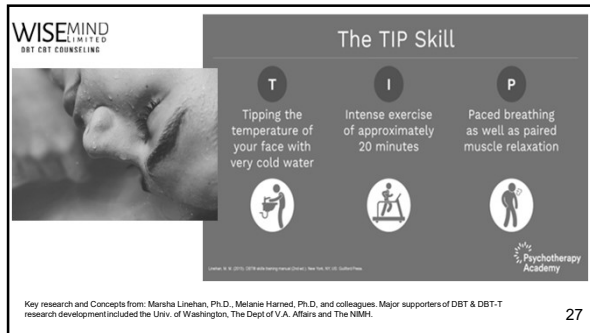


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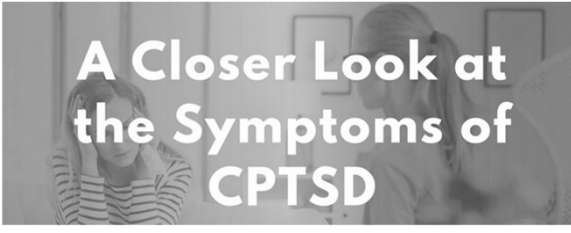
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27

27

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A Closer Look at the Symptoms of CPTSD

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PTSD typically results from "short-lived trauma", or traumas of time-limited duration. Complex PTSD stems from chronic, long-term exposure to trauma in which a victim has limited belief it will ever end or cannot foresee a time that it might. This can include: child abuse, long-term domestic violence, being held in captivity, living in crisis conditions/a war zone, child exploitation, human trafficking, and more.

BEAUTY AFTER BRUISES.ORG

Key research and Concepts from: Marsha Linehan, Ph.D., Melanie Harned, Ph.D., and colleagues. Major supporters of DBT & DBT-T research development included the Univ. of Washington, The Dept of V.A. Affairs and The NIMH.

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29

Affect Dysregulation: Symptoms

- Intense physiological reactivity
- Intense affective reactivity
- Inability to soothe self or find comfort in safe relationships
- Explosive or extremely inhibited anger (may alternate)
- Compulsive or extremely inhibited sexuality (may alternate)
- Self-harming behaviors
- Health-risk behaviors
- Persistent dysphoria
- Chronic suicidal preoccupation
- Suicide attempts

Judith L. Herman, M.D.

Complex PTSD:

D: Distortions in Relationships

- Intense unstable relationships
- Isolation and withdrawal
- Persistent distrust
- Repeated failures in self-protection
- Repeated search for rescuer (may alternate with isolation and withdrawal)

Judith L. Herman, M.D.

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30

30

PTSD and complex PTSD symptoms

source: European Journal of Psychotraumatology 2013, 4: 20796
 http://dx.doi.org/10.1080/18089630.2013.808706

PTSD **Complex PTSD**

<http://traumadissociation.com/complexptsd>

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Social anxiety & hyperarousal

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Distinguishing between Complex PTSD and Borderline Personality Disorder in 280 female child abuse survivors seeking PTSD treatment

Complex PTSD (7.8% met BPD criteria)
Borderline Personality Disorder (44.6% met PTSD criteria, 4.9% met PTSD)

Four BPD symptoms greatly increased the odds of being in the BPD category to the Complex PTSD also being likely to meet criteria for a lifetime history of self-harm and suicidal ideation, parasocial relationships, and impulsivity. European Journal of Psychotraumatology 2014, 5: 20807-20910. doi:10.1080/18089630.2014.922898

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33

Things I Didn't Know Were Symptoms of C-PTSD

- Getting overwhelmed in crowds
- Getting upset or angry at a loud alarm
- Ordinary nightmares (that have nothing to do with the circumstances) just about nightmares much more often than the average person
- Getting sharp pains in your back/muscles/shoulders that make it hard to breathe (due to hyperventilation/constant high anxiety)
- Learning that "high anxiety" does not mean "operational readiness" like other people have with panic attacks and not feeling that they can accomplish things. PTSD anxiety just means "this benefits anxiety" that allows you work to high-stress things (even as an interview) to avoid appearing.
- Feeling constantly scared like you have to check after something, even if you're just at home. I spend hours on facebook, pinterest, watching tv reading books, reading etc, never get tiring/feeling alone... because if you stop... the darkness is there
- Thinking too slowly before bed. This is a symptom of high anxiety because you're trying to calm down and fall asleep in a "safe world" where people are looking out for you and caring for you.
- Trouble falling asleep (which is distinct from insomnia) because turning off electronic etc doesn't help since your heart rate/light or light response is engaged
- Moments of seeing heart rates has gotten to 120bpm for five hours that make you feel like you're waiting for something to happen.
- Exaggerated startle response. When I was a kid I used to hide behind curtains to surprise my parents. Ten years ago my friend hid under my desk to scare me. I literally screamed, fell out of the chair, and started crying. One can laughing because she thought the joke went well, and then got concerned because I kept crying.
- Possibly "hiding" if a kid she with had trauma/trauma/trauma because it "was already turned anyway"

I'm exhausted from trying to be stronger than I feel.

PictureQuotes.com

Key research and concepts from: Marsha Linehan, Ph.D., Melanie Harned, Ph.D., and colleagues. Major supporters of DBT & DBT-T research development included the Univ. of Washington, The Dept of V.A. Affairs and The NIMH.

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Complex Trauma

High-Risk Behavior

Clients engage in high-risk, impulsive, and self-damaging behaviors that often function to provide short-term emotional relief.

- **Life-threatening behaviors:** suicidal and non-suicidal self-injury, suicide crisis behaviors
- **Impulsive behaviors:** substance use, disordered eating, unsafe sex, physical aggression, reckless driving, gambling, excessive spending

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Severe Disability

Clients typically exhibit severe impairment in multiple domains of functioning that make it difficult to fulfill normative social and societal roles.

- **Interpersonal problems:** unstable and high-conflict relationships, limited social support
- **School & work problems:** skipping school, failing classes, losing jobs, chronic unemployment
- **Physical health:** frequent illness, multiple medical conditions, chronic pain
- **Financial & housing problems:** extreme poverty, unable to pay bills, unstable housing

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Difficult to Treat
Clients typically engage in a variety of behaviors that interfere with treatment and make it difficult to engage in therapy.

- **Non-attentive behaviors:** e.g., missing sessions, dissociation or intoxication in sessions
- **Non-collaborative behaviors:** e.g., not speaking, argumentative, withdrawn, inflexible
- **Non-compliant behaviors:** e.g., refusing to engage in treatment tasks or complete homework



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37

37

Multi-Diagnostic
Clients typically have multiple severe mental disorders in addition to PTSD.

Common co-occurring disorders:

- Mood disorders
- Anxiety disorders
- Alcohol and drug use disorders
- Personality disorders
- Eating disorders
- Dissociative disorders



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38

38

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A Tension in Treatment for PTSD and Comorbid Problems

Treatment Guidelines	Clinical Practice
Use trauma-focused EBTs for all PTSD patients regardless of comorbidities	Do not use trauma-focused EBTs for PTSD patients with serious comorbid problems

Synthesis


Key research and Concepts from: Marsha Linehan, Ph.D., Melanie Harned, Ph.D., and colleagues. Major supporters of DBT & DBT-T research development included the Univ. of Washington, The Dept of V.A. Affairs and The NIMH.

39

39

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Melanie Harned, PhD developed DBT-PE because PTSD was limiting benefits of DBT in this population, and this population also couldn't typically get access to PTSD programs.



The Typical Client Receiving DBT PE:


- Has a lifetime history of more than 10 types of trauma that started before age 6.
- Has attempted suicide 2-3 times and engaged in non-suicidal self-injury more than 60 times in the past year.
- Meets criteria for 7 current psychiatric diagnoses including PTSD.
- Experiences serious impairment in social, occupational, and/or school functioning

Key research and Concepts from: Marsha Linehan, Ph.D., Melanie Harned, Ph.D., and colleagues. Major supporters of DBT & DBT-T research development included the Univ. of Washington, The Dept of V.A. Affairs and The NIMH.

40

40

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PTSD
Clients have typically experienced multiple, often chronic traumas starting in childhood.

High-Risk Behavior
Clients engage in life-threatening and other impulsive, self-damaging behaviors.

Multi-Diagnostic
Clients have multiple, often severe, mental disorders in addition to PTSD.

Difficult to Treat
Clients usually have difficulty attending, collaborating, and staying engaged in therapy.

Severe Disability
Clients typically exhibit severe impairment that makes it difficult to fulfill normative social roles.

Key research and Concepts from: Marsha Linehan, Ph.D., Melanie Harned, Ph.D., and colleagues. Major supporters of DBT & DBT-T research development included the Univ. of Washington, The Dept of V.A. Affairs and The NIMH.

41

41

DBTPE

What is DBT PE?

The Dialectical Behavior Therapy Prolonged Exposure (DBT PE) protocol is designed to treat PTSD among suicidal, self-injuring, and multi-diagnostic adolescents and adults receiving Dialectical Behavior Therapy (DBT). The DBT PE protocol is based on Prolonged Exposure (PE) therapy, a highly effective treatment for PTSD that utilizes *in vivo* and imaginal exposure followed by processing as the core treatment strategies. The integrated DBT and DBT PE protocol treatment uses a stage-based approach to comprehensively address the full range of problems experienced by high-risk, severe, and complex clients with PTSD. © 2018 HARNED CONSULTING, LLC

DBTPE is also the name for the research, education and professional consultation organization of Melanie Harned, PhD., located in Research, Education and Professional Consultation Organization of Melanie Harned, PhD.

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42

42

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The Impact of PTSD in BPD

- 30-50% of individuals with BPD also have PTSD (e.g. Harmed et al., 2010; Pagura et al., 2010; Zanetti et al., 2004)
- PTSD is associated with greater impairment:
 - Suicidal and self-injurious behavior
 - Depression
 - Anxiety
 - Poorer physical health
 - Poorer global functioning

(e.g. Harmed et al., 2010; Zornick et al., 2003; Edman et al., 2006; Ruscch et al., 2007)

- Clients with more severe PTSD are likely to be more impaired in a variety of areas during treatment.
- When PTSD severity is reduced, it is associated with subsequent improvements in multiple outcome domains.

THEREFORE

It is critical to treat PTSD during DBT.

Key research and Concepts from: Marsha Linehan, Ph.D., Melanie Harmed, Ph.D., and colleagues. Major supporters of DBT & DBT-T research development included the Univ. of Washington, The Dept of V.A. Affairs and The NIMH.

43

43

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Recommended Strategies for Addressing PTSD in DBT for BPD (Linehan, 1993)

Stage 1 DBT

- Primary target is behavioral dyscontrol.
- Focus is on increasing behavioral skills.
- Use a present-focused approach to address PTSD-related problems.
- Avoid emotionally processing past trauma.

Stage 2 DBT

- Primary target is PTSD.
- Use DBT exposure-based procedures in a very focused fashion, -- or --
- Integrate an established exposure-based PTSD treatment into DBT.

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44

44

change is difficult.

not changing is fatal.

A Dialectical Framework for Trauma Reactions

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45

45

Know What You're Treating: Targets for Stage II

TARGET	GOAL
Quiet Desperation	Normative Emotional Experiencing & Expression
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

16

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46

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"COMPLEX PTSD" PRODUCES LONG-TERM EFFECTS ON MULTIPLE SPHERES OF BEHAVIORAL FUNCTIONING; AND THOSE PROBLEMS ALIGN PARTICULARLY WELL WITH DBT SKILLS TRAINING.

47

47

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THERAPISTS' DILEMMAS

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THERAPY-CLIENT RELATIONSHIP TOPICS FOR REFLECTION/SELF-CONSIDERATION/CONSULTATION

- C-PTSD and BPD clients both can be expected to act out their attachment styles in their all relationships, including with you of course. That will prompt a set of responses in us as the therapists (that at times may be quite intense or even subtle yet they are critical parts of the dynamic).
- We also have OUR vulnerabilities in relationships (Do you tend to have strong "rescuing" urges perhaps? Or perhaps a tendency to not manage certain stronger emotions as effectively as you'd like in therapy?--especially during "intense/fear/anger/sadness: experiencing?).
- Healthy Limits and Boundaries, Radical Genuineness and Privacy with Clear Roles in the Relationship? How you are behaving and what you chose to do, how aware are you of your own limitations and limited emotional reserves? Is something you're doing in therapy that, upon closer consideration, is REALLY being done to meet YOUR OWN NEEDS, and not to benefit the client and the treatment process?

49

49

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- Consider your LIMITS (boundaries, capacities, how you'd evidence healthy limits without rejecting a client--and would you ORIENT the client toward limits BEFORE there is an issue? Or might you be likely to AVOID such a discussion?)
- What do you think is critical for the relationship in terms of mutual trust, emotional safety, how and when will you seek supervision/consultation? Are clients getting so attached to you it's hard for them to end the relationship when it's time, or is it hard for YOU to let them go? Do you have a tendency to "kick-out" or "fail-out" clients from treatment?
- Transference and countertransference dynamics: are you aware of these dynamics and comfortable addressing these in clinical supervision in a meaningful way? Manage vicarious trauma and burn-out?
- Are you able to use positive regard and hope as an asset in your treatment? Are you at "equal personhood stance" in regard to your clients and balance that with your requirement to be the leader in therapy, being a confident expert that is still warm and human at the same time? Can you be helpfully vulnerable in the sessions, too open, or can you be cold? RADICALLY GENUINE and PROFESSIONAL?

50

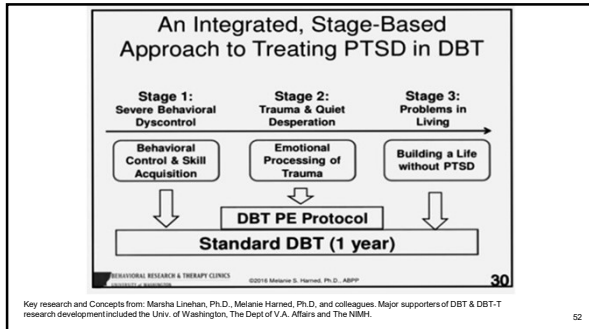
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<p>Hyperaroused</p> <p>Arousal levels too high, fight or flight kicks in and trauma processing is too overwhelming</p>	<p>Opposite Action</p> <p>Changing <i>ineffective</i> emotions by ACTING OPPOSITE to the emotion</p> <ul style="list-style-type: none"> • Fear – Urge: Freeze, run, avoid – Opposite action: Approach • Anger – Urge: Attack, hit, yell – Opposite action: Gently avoid; do something nice • Sadness – Urge: Withdraw, cry, isolate – Opposite action: Get active • Guilt/Shame – Urge: Hide/avoid – Opposite action: Face the music; repair mistakes
<p>Window of tolerance</p> <p>Arousal levels are regulated so that emotions can be activated but are not so overwhelming that trauma processing stops</p>	
<p>Hypoaroused</p> <p>Arousal levels are inhibited. Processing cannot take place as no access to emotion</p>	

They received their inspiration from the research of Peter, Robert, and Thomas, Ph.D., and colleagues. Major supporters of DBT & DBT-T research development included the Univ. of Washington, The Dept of V.A. Affairs and The NIMH.

51

51



52

PTSD Outcomes in DBT

- **13-33%** achieve diagnostic remission from PTSD during one year of DBT.
 - Population: recently and recurrently suicidal and self-injuring women with BPD and PTSD (Harned et al., 2008; Harned et al., 2014)
- PTSD predicts worse outcomes across the course of DBT.
 - Less improvement in suicidal and self-injurious behaviors (Baroncic & Priebe, 2013; Harned et al., 2010)
 - Lower likelihood of eliminating acute suicide risk (high suicidal ideation + intent + plan) (Harned et al., 2010)

Acceptability and Feasibility

- At intake, 76% of clients preferred to receive DBT + DBT PE.
 - 24% preferred DBT alone, 0% preferred PE alone
- 60% initiated the DBT PE protocol.
 - At week 20 of DBT on average (range = 6-37)
 - Primary barrier to initiation was premature dropout from DBT
- Of those who initiated the DBT PE protocol, 73% completed it.
 - Average of 13 sessions (range = 6-19)

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 27

BEHAVIORAL RESEARCH & THERAPY CLINICS ©2016 Melissa S. Harned, Ph.D., ABPP (Harned et al., 2012, 2014)
 42

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53

Stage 2 -

- ▶ Moderate emotions from excruciating and uncontrollable to modulated emotional experiencing
 - ▶ Decrease
 - ▶ Intrusive symptoms (flashbacks, memories, hecklers)
 - ▶ Avoidance of emotions (increase emotional awareness)
 - ▶ Withdrawal (increase exposure to life)
 - ▶ Decrease emotional dysregulation (heightened and inhibited)
 - ▶ Self- invalidation (increase self-validation)
 - ▶ Mood dependency of behaviors (increase accurate communication of emotional and physical experience)

Feel the feeling but don't become the emotion. Witness it. Allow it. Release it.
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54

"It takes courage to live through sufferings, and it takes honesty to observe it."

C.S. Lewis

Exposure Homework Sheet

Exercise: What will I do? How long for?

Day / Thoughts	Anxiety rating	Anxiety rating	Anxiety rating	Duration	Comments
Time					
What might happen?	1-10	1-10	1-10		What happened? What did you do? How was your anxiety affected? What helped? What didn't help?
What's the worst thing about it?	Before	During	After		How likely is this to happen?
					What could you do differently next time?

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55

55

Using DBT to Address Problems

- DBT is used to target any problems that may occur during the DBT PE protocol
 - Increased suicide or self-injury urges or behaviors
 - Treatment noncompliance
 - Major life problems (e.g., relationship, employment, housing, financial problems)
 - Other co-occurring disorders (e.g., eating disorders, major depression, substance use)

Use standard DBT strategies, skills, and protocols to target these problems, ideally without having to stop PTSD treatment.

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56

56

Suicidal and Non-Suicidal Self-Injury

Category	DBT (%)	DBT+DBT PE (%)
Any Suicide Attempt	40	17
Any Non-Suicidal Self-Injury	100	67
Treatment Year Total		

Among treatment completers, clients in DBT+DBT PE were 2.4 times less likely to attempt suicide and 1.5 times less likely to self-injure than those in DBT.

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57

57

Summary of Findings

It is feasible and safe to implement PE and CPT with BPD patients who meet the eligibility criteria for these treatments.

BPD does not impact the rate of change in PTSD or other outcomes during these treatments.

Using these treatments to reduce PTSD severity may lead to improvements in BPD.

These treatments may be insufficient for many BPD patients (~90% have poor end-state functioning after treatment).

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58

58

PROVEN RESULTS

71-80%
remit from PTSD

2.4x
fewer suicide attempts


80%
achieve normative global functioning

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59

59

FEATURES OF MINDFULNESS	
Self-awareness	Focal point of experience
Feeling	Capacity to experience emotional tone of an event or situation.
Foresight	Capacity to predict outcomes.
Courage	Capacity to step outside the bounds of convention.
Skepticism	Capacity to suspend judgement
Language	Capacity to abstract
Memory	Capacity to reassess knowledge & feeling
Temporality	Appreciation of linear & cyclical time.
Spirituality	Appreciation of universal interconnectedness.
Imagination	Capacity to simulate
Loving-kindness	Appreciation of universal compassion
Agency	Capacity to act ethically on & in the world



DBT SKILL:

HALF SMILE

What's a half smile? It's a deliberate smile just small enough to trick your mind into producing joyful thoughts & feelings without slipping in under the brain's Fake Smile Detector.

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60

60

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THERAPIST & CLIENT SUGGESTED RESOURCES

TEXTS AND WORKBOOKS:

Dana, Deb A. (2018). *The polyvagal theory in therapy: engaging the rhythm of regulation*. With forward by: Stephen W. Porges. New York, NY. W.W. Norton & Company

Dana, Deb A. (2020). *Polyvagal exercises for safety and connection: 50 client-centered practices*. New York, NY. W.W. Norton & Company.

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61

61

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THERAPIST & CLIENT SUGGESTED RESOURCES

TEXTS AND WORKBOOKS

Schwartz, A. (2016). *The complex PTSD workbook: a mind-body approach to regaining emotional control and regaining control*. Berkeley, CA. Athena Press.

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62


62


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THERAPIST RESOURCES

WEBSITES WITH WEBINARS, EDUCATION RESOURCES, ORGANIZATIONS

 The International Society for Traumatic Stress Studies. www.istss.org

 Behavioral Tech: A Linehan Institute Training Company: www.behavioraltech.org

 DBTPE Organization: Research, Education and services. <https://dbtpe.org/> Founder: Melanie Harned, PhD.

63

63

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64

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65

65

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