Advanced Treatment Techniques & Targets in Dialectical Behavior Therapy:

Emerging Best Clinical Practices for DBT-Trauma Care & Co-Occurring Complex Presentations

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

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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
400 Genesee Street Suite C, Delafield, WI 53018
(262) 744-5201
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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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.

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1. DBT is designed for the multi-problemed 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
2. interventions
3. 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.

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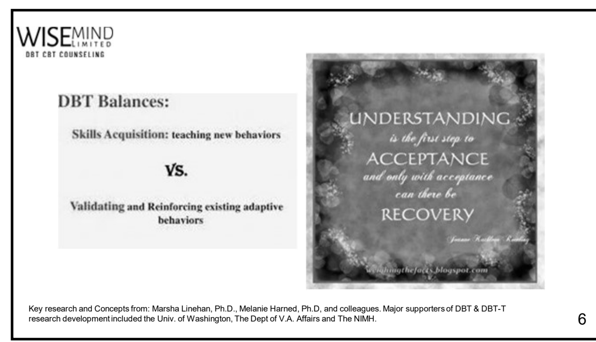

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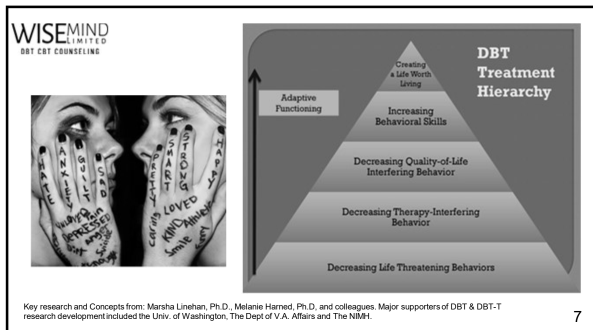

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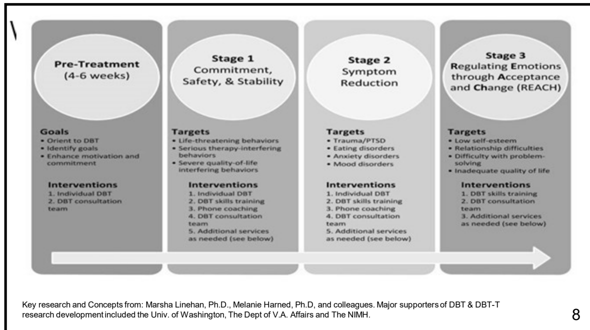

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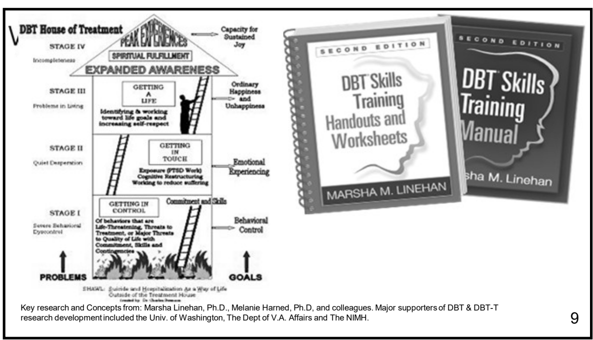

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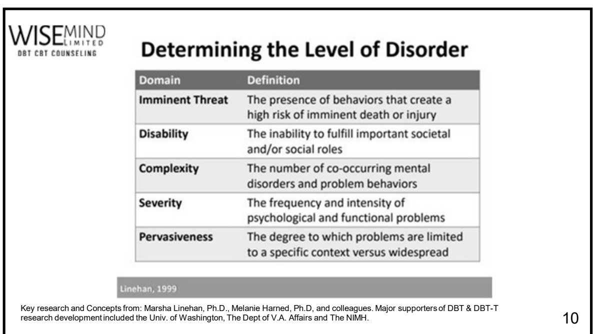

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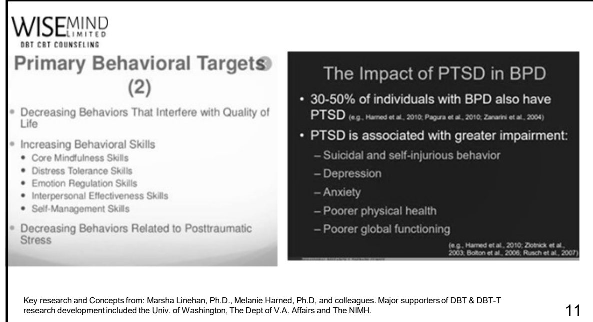

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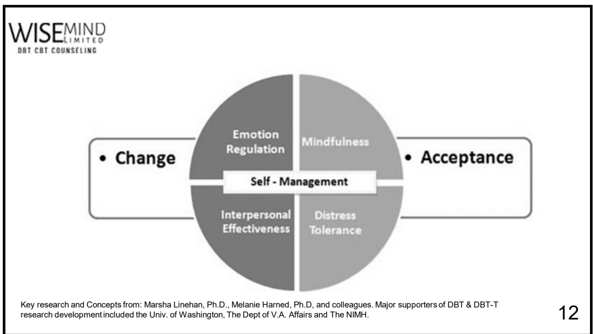

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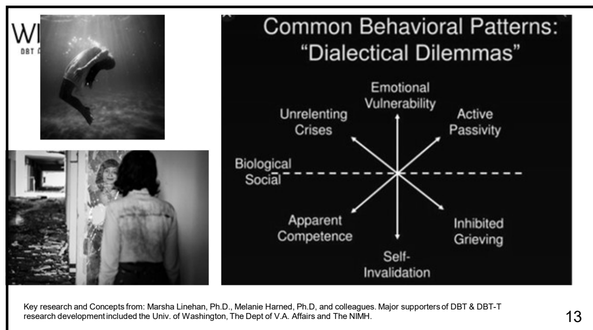

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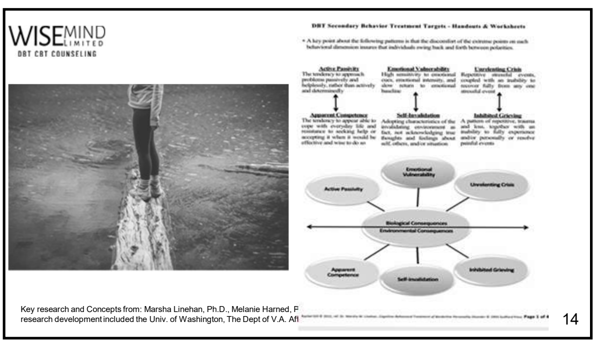

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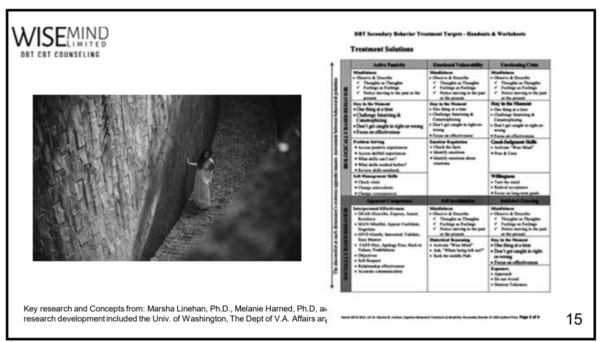

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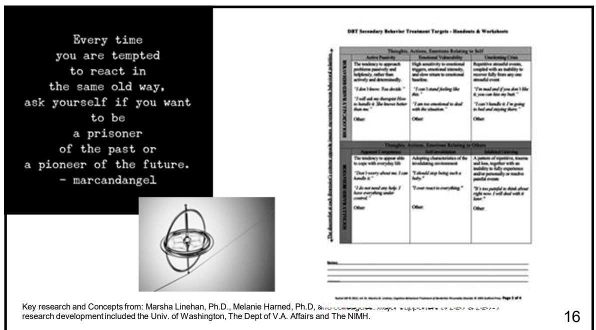

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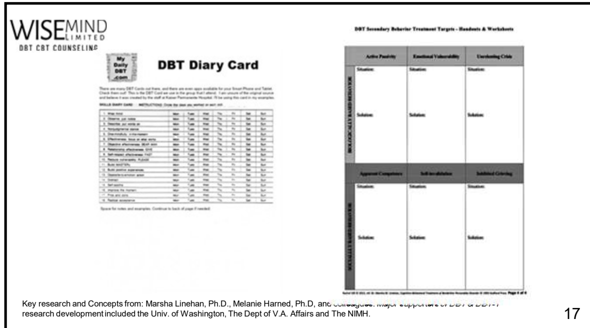

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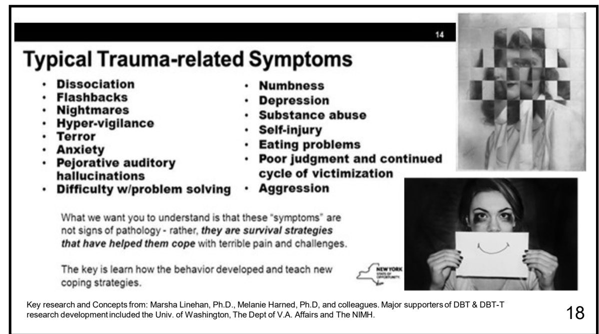

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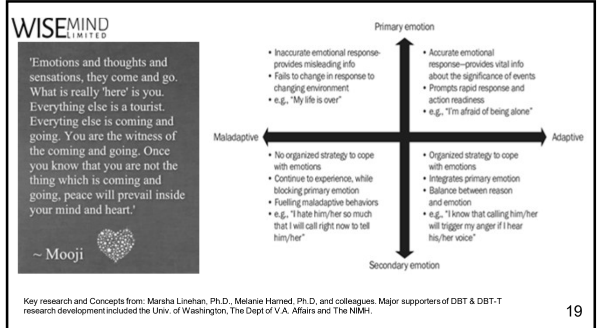

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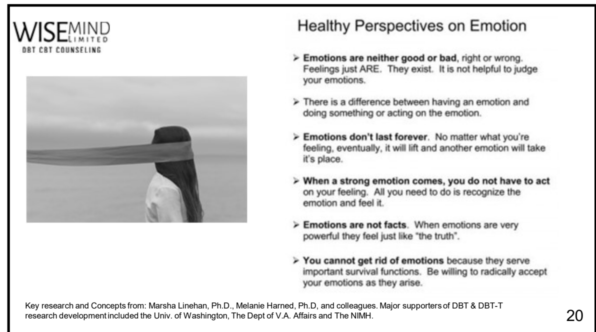

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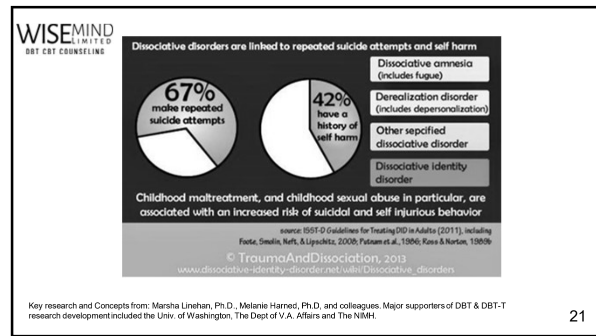

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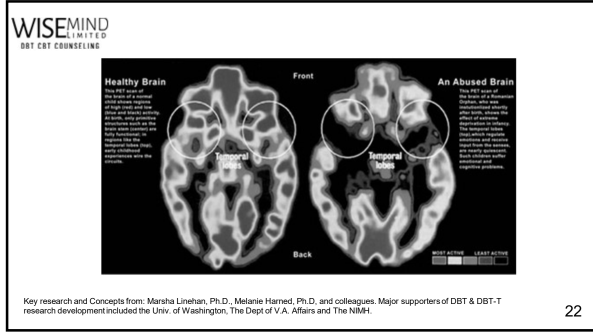

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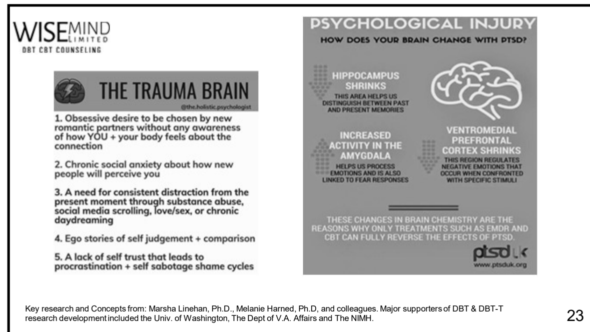

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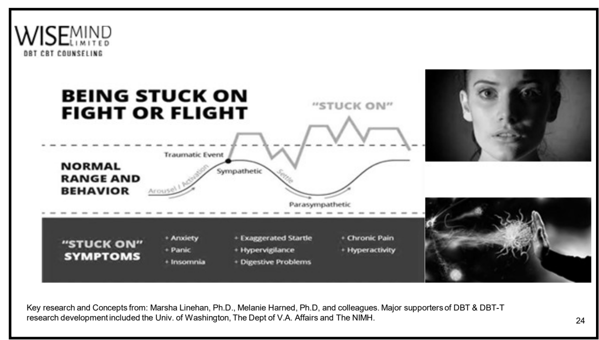

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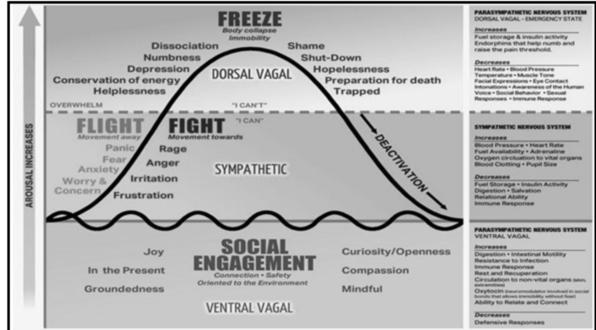

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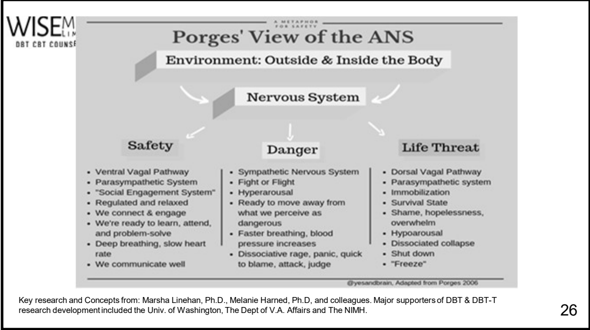

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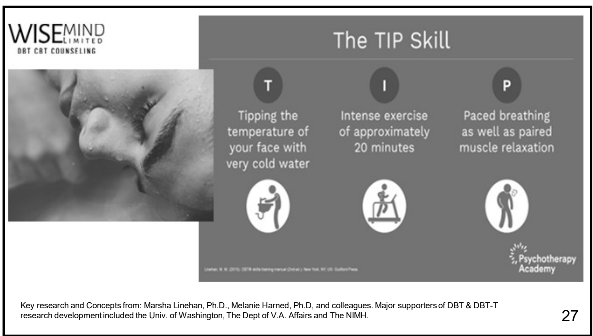

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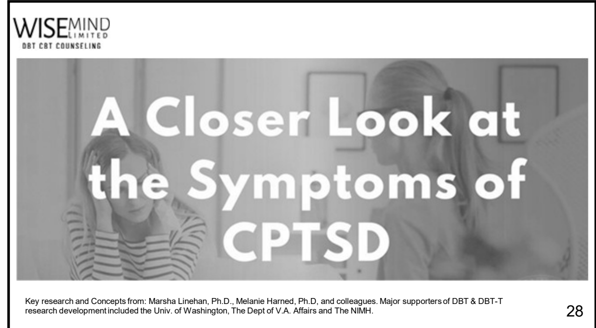

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PTSD typically results from "short-lived trauma", or traumas of time-limited duration. Complex PTSD stems from chronic, long-term exposure to trauma in which a victim has limited belief it will ever end or cannot foresee a time that it might. This 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.*

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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)

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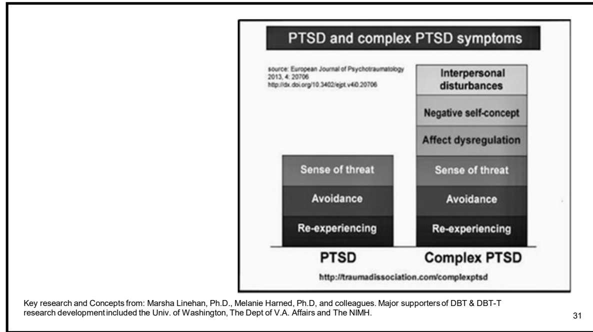

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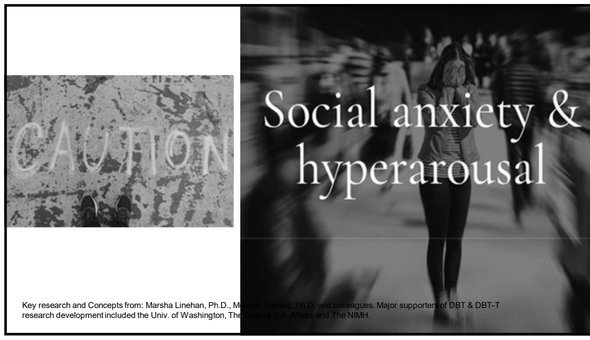

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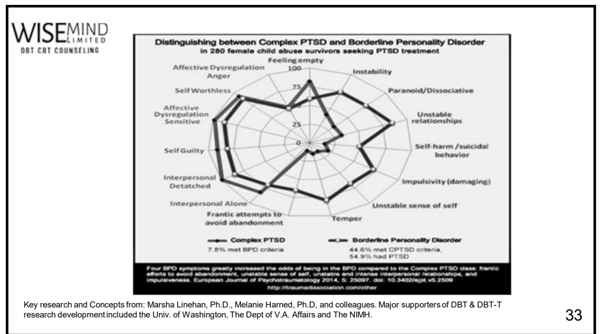

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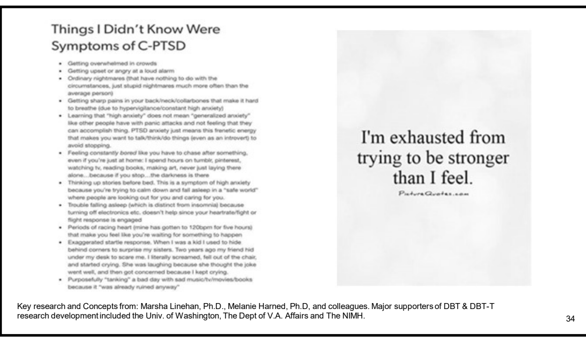

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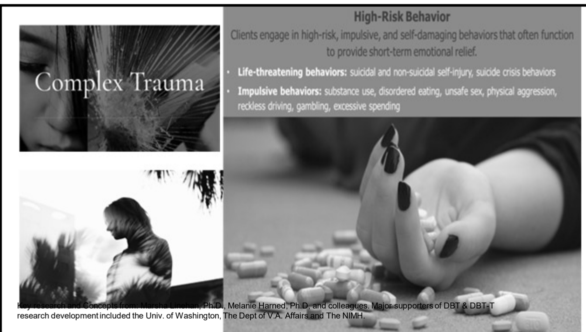

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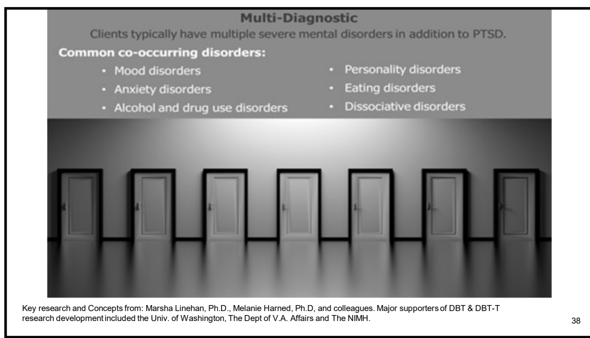

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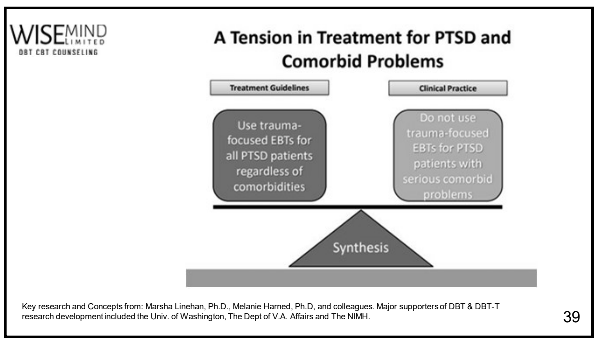

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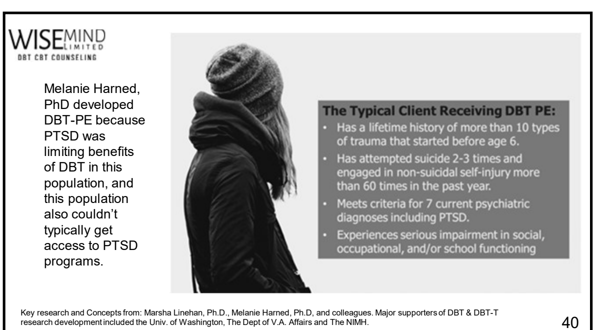

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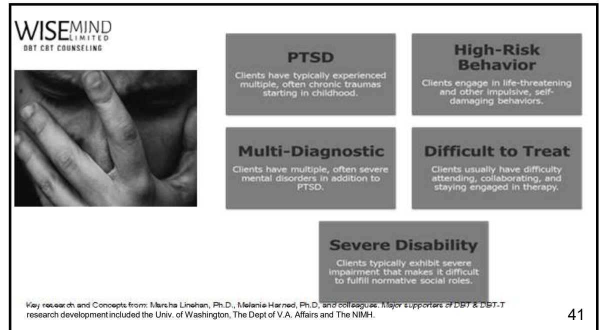

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What is DBT PE?

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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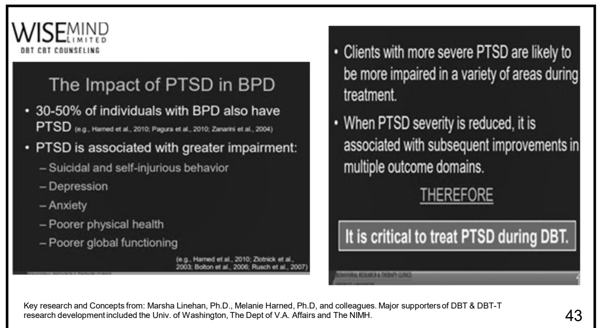

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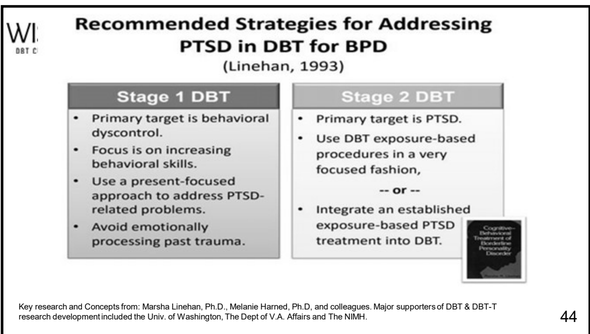

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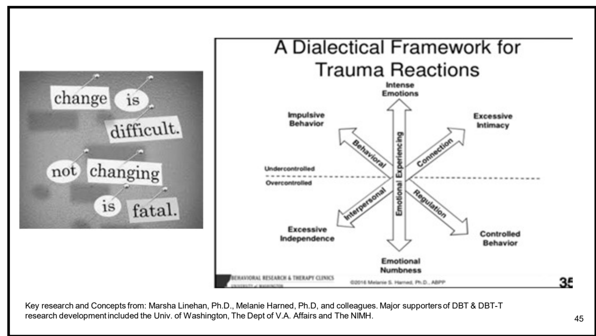

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Know What You're Treating: Targets for Stage II

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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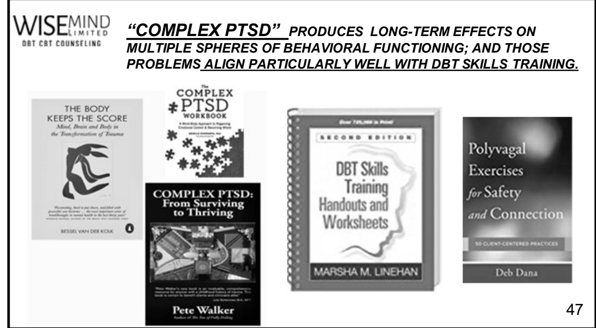

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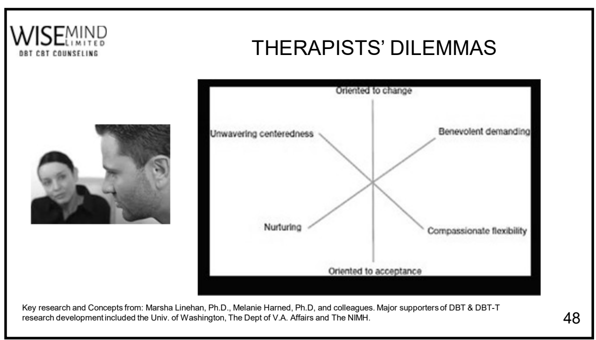

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THERAPY-CLIENT RELATIONSHIP TOPICS FOR REFLECTION/SELF-CONSIDERATION/CONSULTATION

- 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?

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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?

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Hyperaroused

Arousal levels too high, fight or flight kicks in and trauma processing is too overwhelming

Window of tolerance

Arousal levels are regulated so that emotions can be activated but are not so overwhelming that trauma processing stops

Hypoaroused

Arousal levels are inhibited. Processing cannot take place as no access to emotion

Opposite Action

Changing **ineffective** emotions by ACTING OPPOSITE to the emotion

- **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

The Mindfulness Clinic

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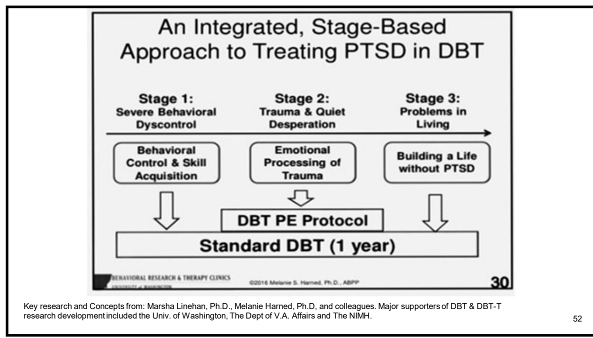

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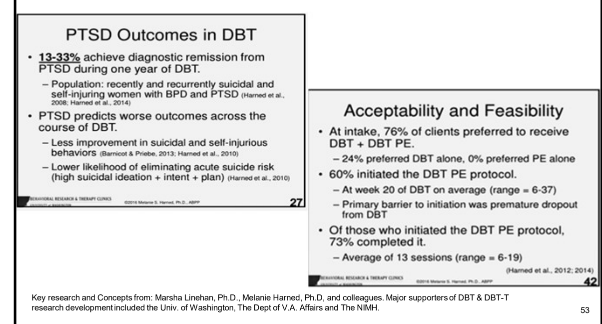

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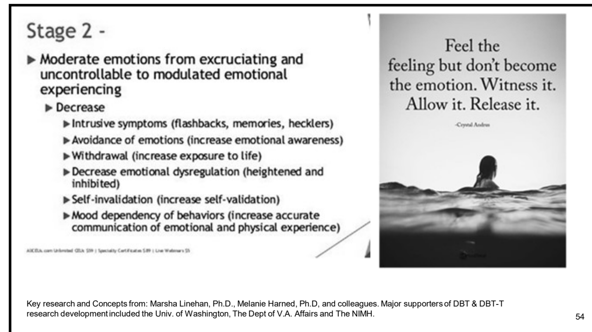

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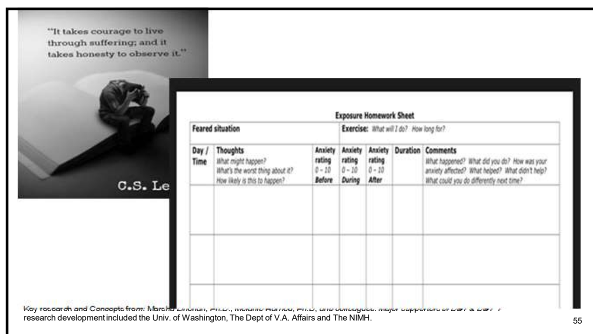

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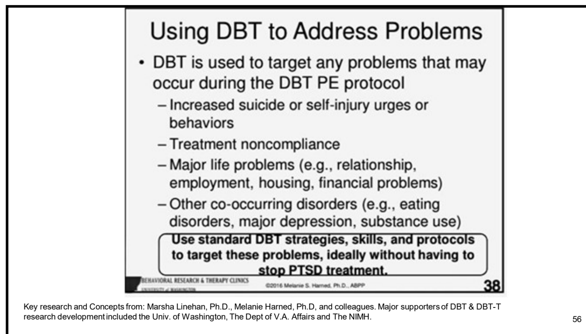

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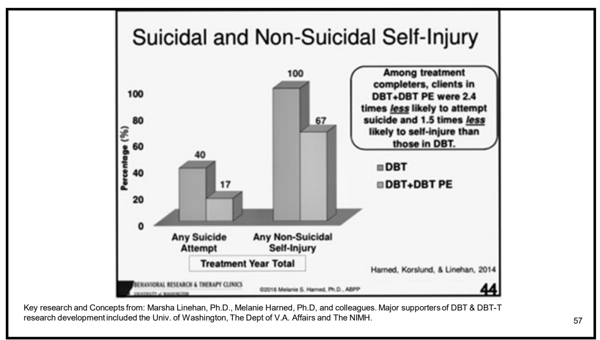

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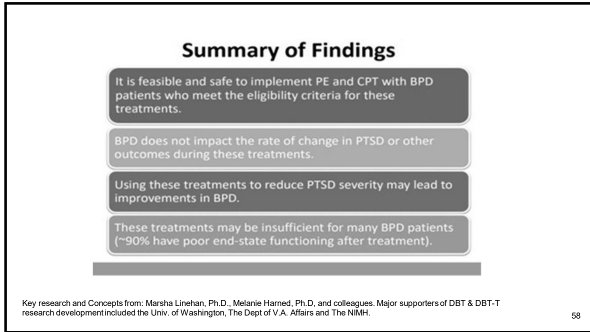

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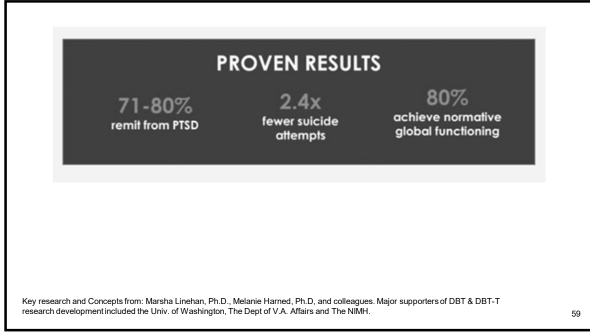

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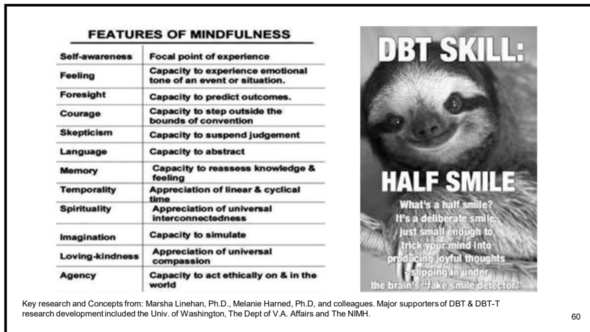

FEATURES OF MINDFULNESS

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

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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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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.

Van der Kolk, B. (2015). *The body keeps the score: brain, mind, and body in the healing of trauma.* New York, NY. Penguin Books.

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THERAPIST RESOURCES

WEBSITES WITH WEBINARS, EDUCATION RESOURCES, ORGANIZATIONS

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

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

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

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REFERENCES (Pg.3)

Rizvi, S. L. & Linehan, M. M. (2005). The treatment of maladaptive shame in borderline personality disorder: A pilot study of "opposite action." Cognitive and Behavioral Practice, 12, 437-447.Wagner, A. W. & Linehan, M. M. (1998). Dissociative behavior. In V. M.

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Wagner, A.W. (2016) "Applications of Dialectical Behavior Therapy to the Treatment of Dissociative Behavior and Other Complex Trauma-Related Problems," A Summary presentation accessed online Oct, 2020. Affiliation:. Portland VA Medical Center Author Contact: amy.wagner@va.gov

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