Dialectical Behavior Therapy for Complex Post-Traumatic Stress Disorder

Milton Z. Brown, Ph.D.

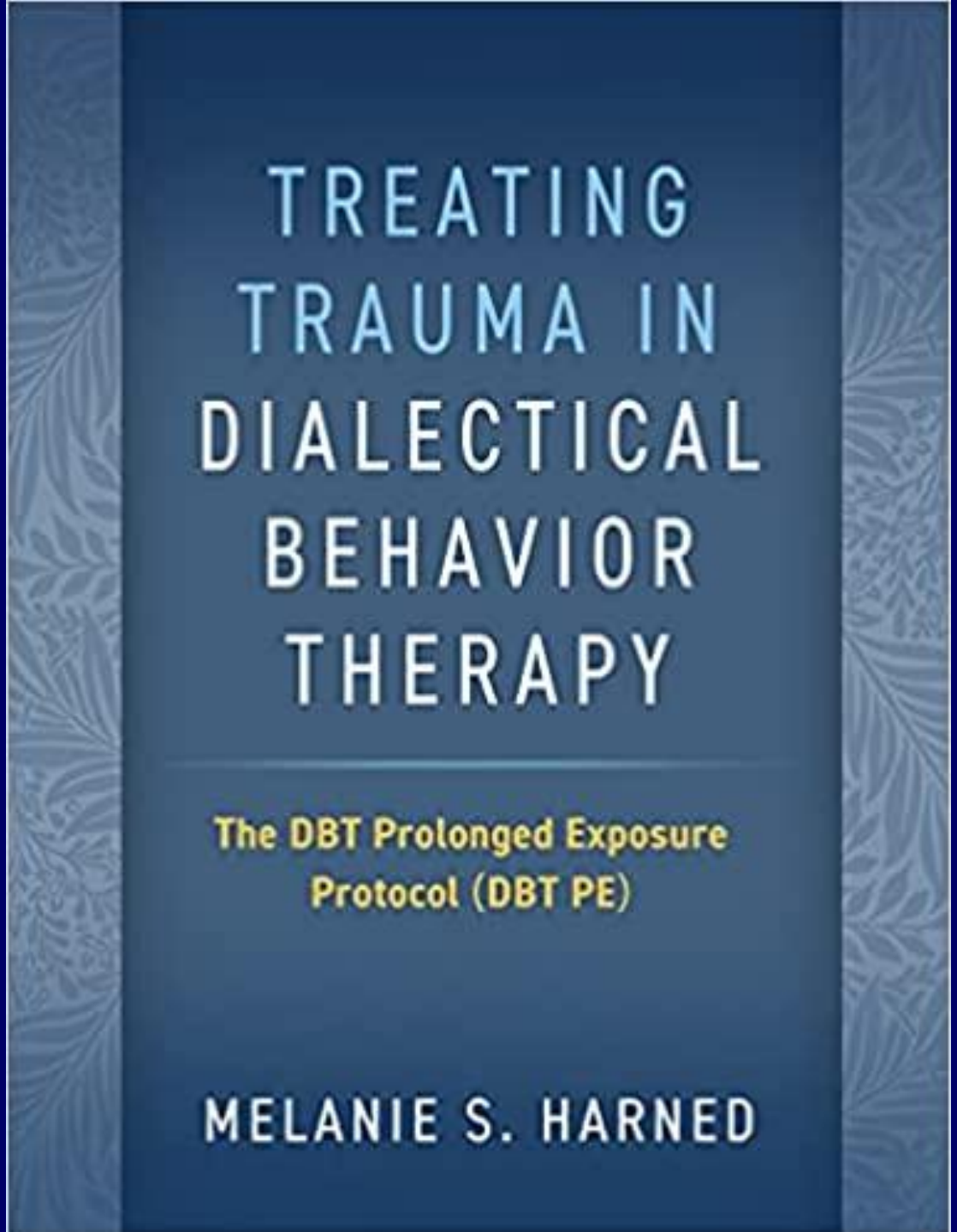
IVAT San Diego International Summit
DBT Center of San Diego
www.dbtsandiego.com
(619) 602-0726

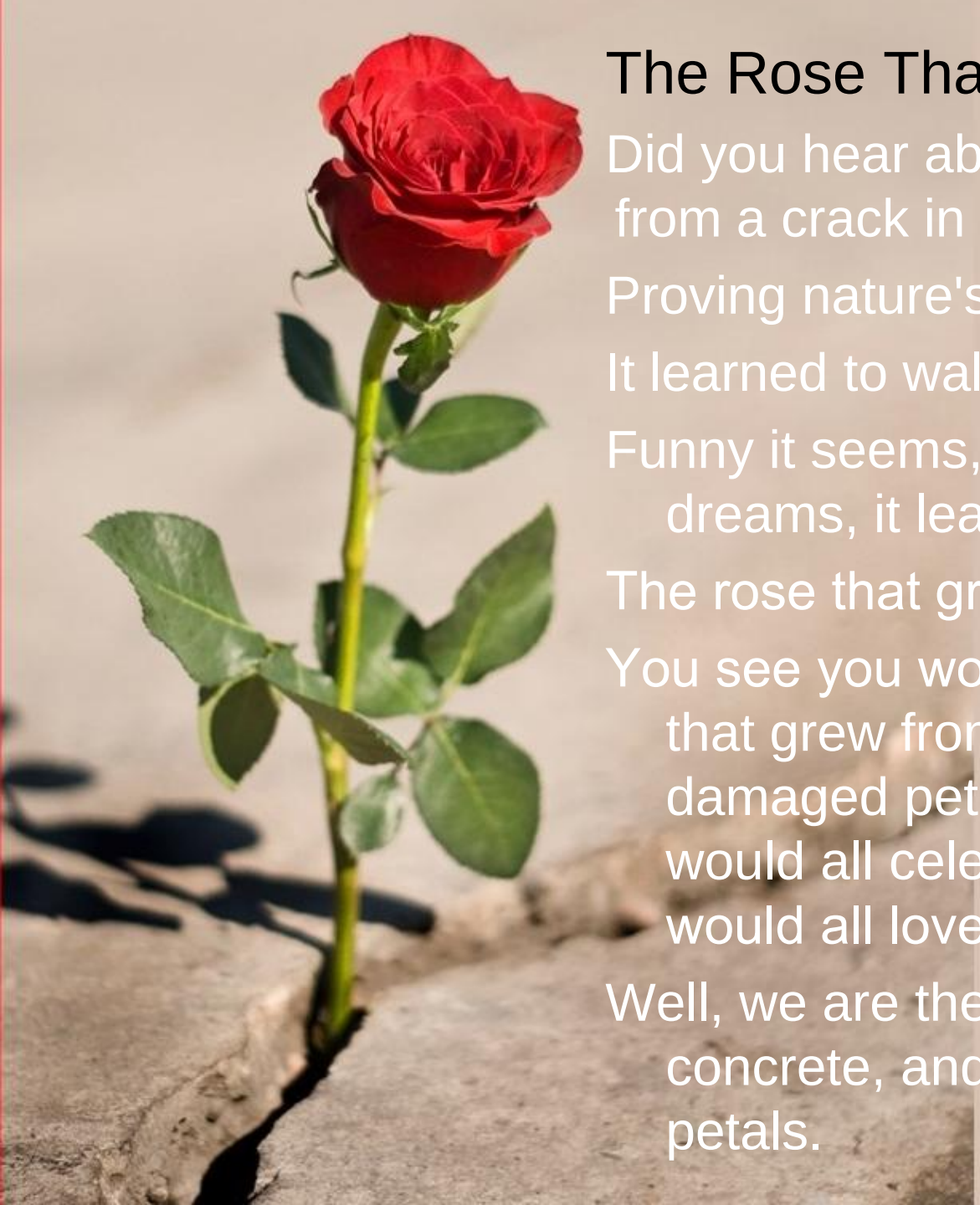
Objectives

1. Review the seven evidence-based psychotherapies for PTSD.
2. How to improve their effectiveness with complex trauma and complex PTSD.
3. Review several rigorous research studies.
4. Review the main Exposure strategies for severe and complex PTSD.
5. Briefly describe standard DBT
6. Not enough time!!

Learn More

1. Lectures (Youtube) on DBT-PE (Harned) and DBT-PTSD (Bohus)
2. Melanie Harned 2022 book
3. Intensive Trainings in DBT (behavioraltech.org), DBT-PE (Harned), DBT-PTSD (Bohus), and PE (Foa)
4. Youtube videos: “DBT Peer Network”
5. All links are here: www.dbtsandiego.com/ptsd


TREATING TRAUMA IN DIALECTICAL BEHAVIOR THERAPY
The DBT Prolonged Exposure Protocol (DBT PE)
MELANIE S. HARNED



The Rose That Grew From Concrete

Did you hear about the rose that grew from a crack in the concrete?

Proving nature's law is wrong

It learned to walk with out having feet.

Funny it seems, but by keeping its dreams, it learned to breathe fresh air.

The rose that grew from concrete…

You see you wouldn't ask why the rose that grew from the concrete had damaged petals. On the contrary, we would all celebrate its tenacity. We would all love it's will to reach the sun.

Well, we are the rose – this is the concrete, and these are my damaged petals.

Everybody has won, and all must have prizes.

The Dodo Bird Verdict

Claim

All bonafide psychological therapies are equally effective

Truth

Most therapies are effective

Some therapies are more effective

Even the best have many failures

Bonafide PTSD Therapies

1/3 of PTSD patients have good outcomes in generic trauma focused therapy

- Supportive Counseling
- Stress Inoculation Therapy

Most have insufficient research evidence

- Somatic experiencing (e.g., Levine, Ogden)

Evidence-Based Therapies

For Adults with PTSD

1. Prolonged Exposure (PE)
2. Cognitive Processing Therapy (CPT)
3. Eye Movement Desensitization and Reprocessing (EMDR)
4. Cognitive Behavioral Therapy (CBT)
5. Cognitive Therapy (CT)
6. Brief Eclectic Psychotherapy (BEP)
7. Narrative Exposure Therapy (NET)

www.apa.org/ptsd-guideline/ptsd.pdf

Evidence-Based Therapies

These therapies are very effective.
No evidence effectiveness differs.

and

They have many failures.

Evidence-Based Therapies

- Half of adults resolve PTSD after 9-12 sessions of trauma-focused EBTs.
- 20% drop out early (PE=EMDR)
- Remission 95% PE vs. 75% EMDR after 18 sessions for non-complex PTSD (p = ns)
- Many more failures for patients with complex trauma and complex PTSD

What is Complex?

Complex Trauma

multiple traumatic events over long periods of time, often beginning in childhood

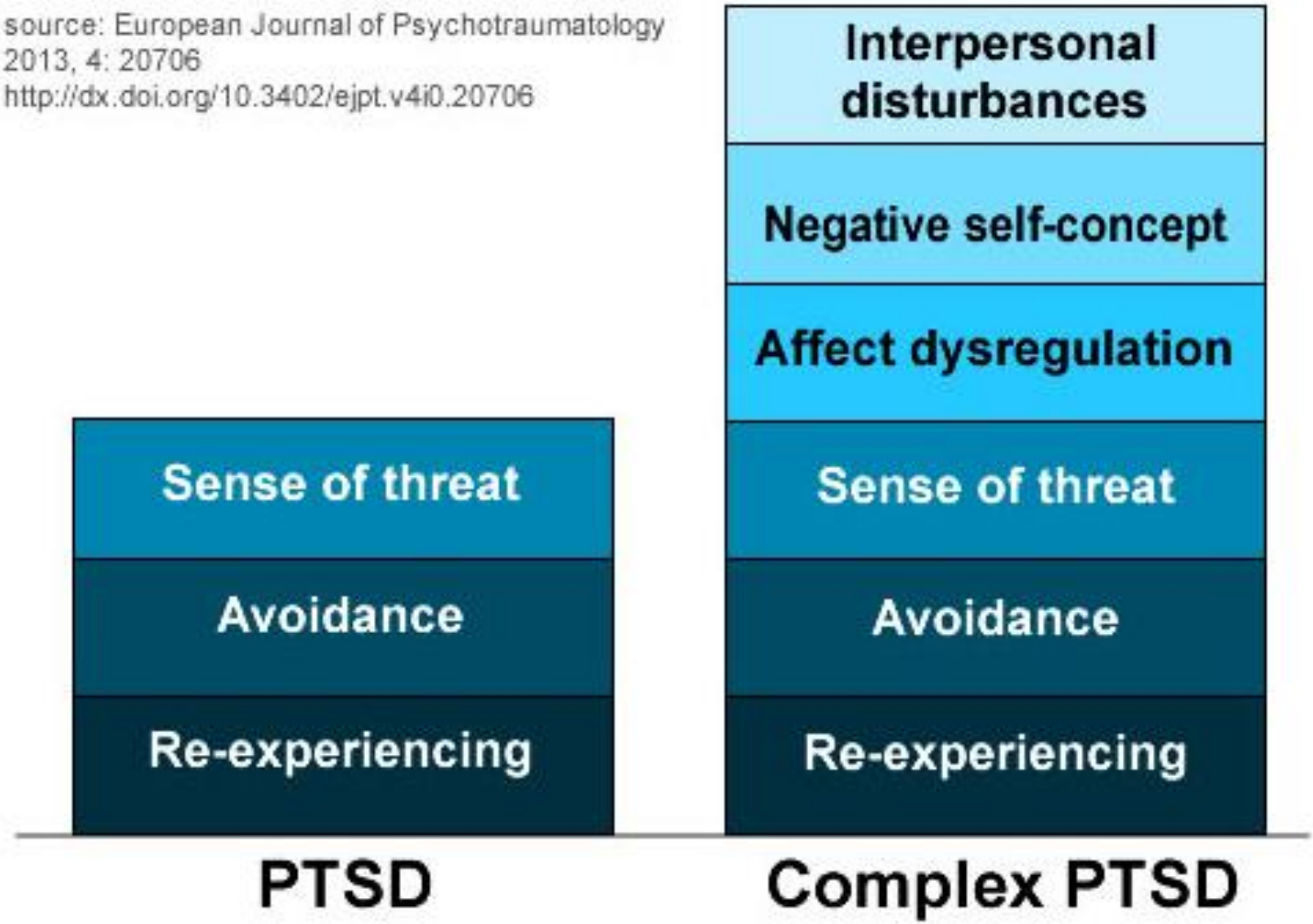
Complex PTSD

PTSD in addition to other major problems like addiction, rage, self-injury, suicide attempts, or borderline personality disorder.

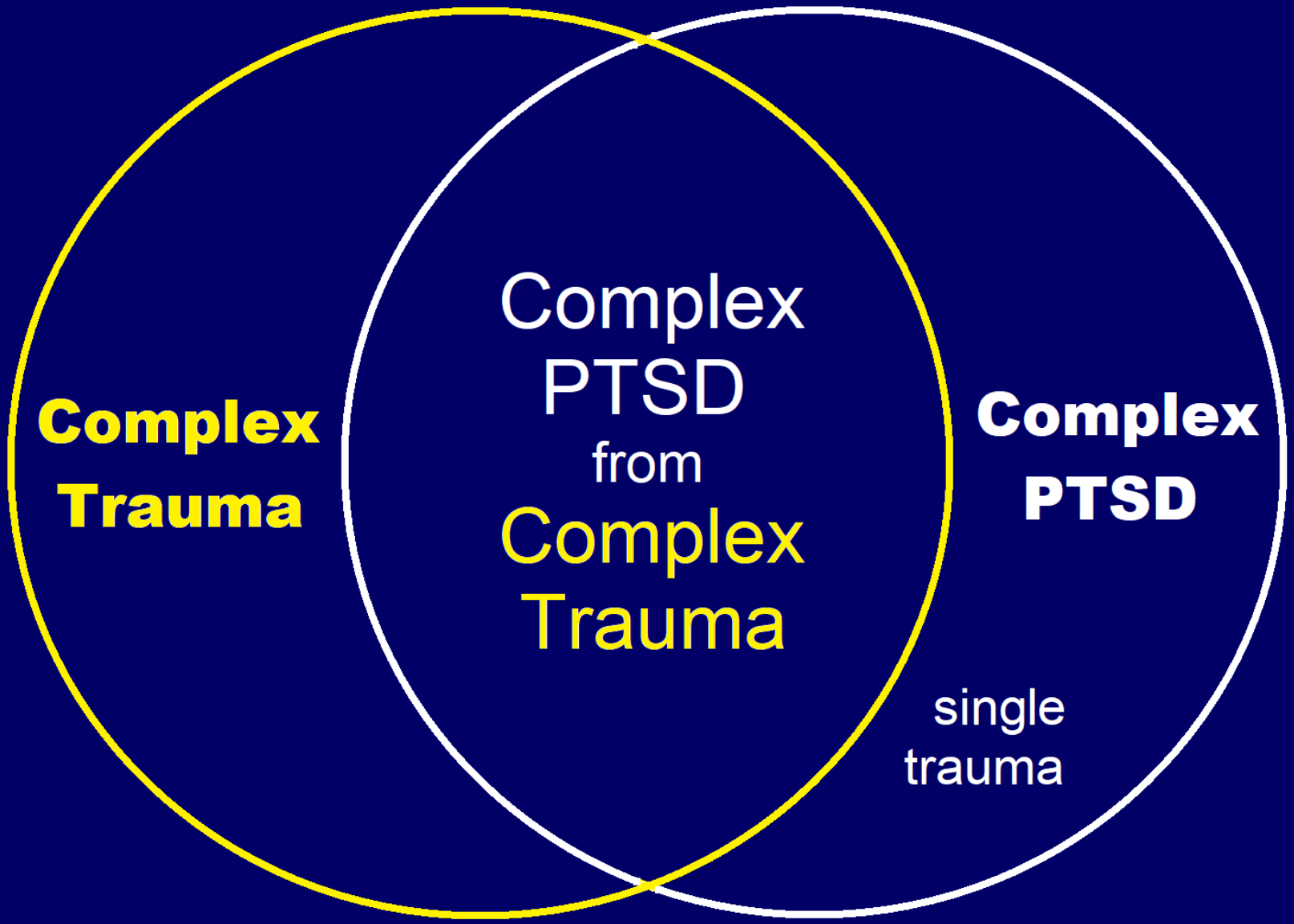
ICD-11 does not require repeated trauma for a CPTSD diagnosis, although they are correlated

PTSD vs. Complex PTSD

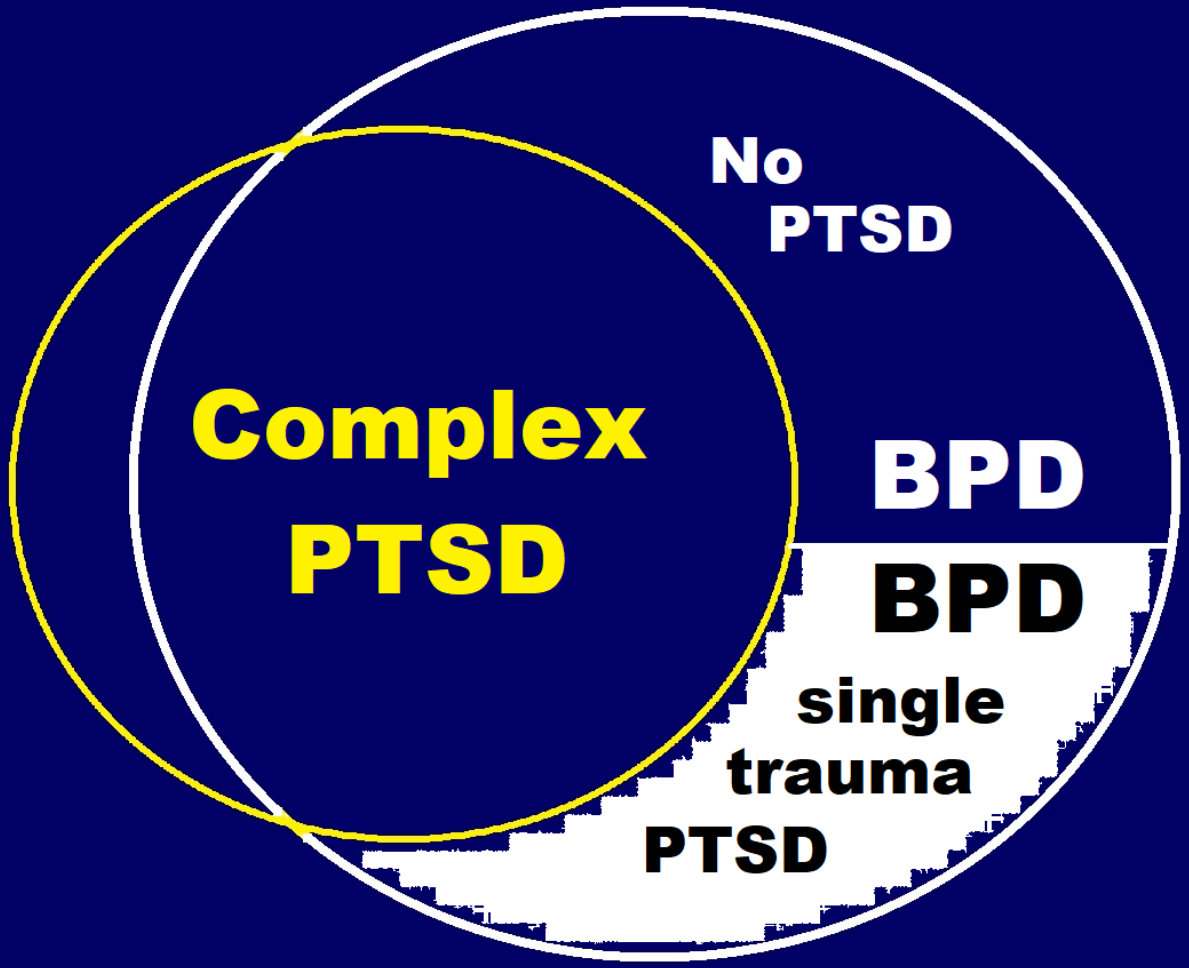
source: European Journal of Psychotraumatology
2013, 4: 20706
http://dx.doi.org/10.3402/ejpt.v4i0.20706



Complex Trauma vs. C-PTSD



Complex PTSD = Borderline PD



What is Complex?

- Half of PTSD is complex PTSD
- 15-30% of people with PTSD also have BPD
- Half of people with BPD also PTSD

PTSD Treatments

- Half as effective for complex trauma compared to single-trauma PTSD
  - 6 months after 8 sessions of EMDR, 67% of patients with complex trauma had PTSD compared to 25% (CAPS<20)
- Complex PTSD (borderline personality disorder) are very hard to treat
  - 2/3 drop out of most therapies (1/3 in DBT)
  - After 1 year of standard DBT, PTSD resolved in less than 40% of BPD patients with CPTSD

Despite what you have heard,

Prolonged Exposure is
NOT
Cruel and Ineffective

Unjustified Therapist Fears

When done skillfully…

- does not make patients worse
- normal drop-out rates
- does not increase self-injury or suicidality
- most people resolve their complex trauma and complex PTSD

PTSD Treatment Options

EMDR is the most popular

Psychology Today online therapist directory in San Diego County in 2021

- 154 Prolonged Exposure
- 200 Cognitive Processing Therapy
- 670 Eye Movement Desensitization and Reprocessing

PTSD Treatment Options

EMDR is the most popular

Certified in California in 2021:

27	Prolonged Exposure
5349	Eye Movement Desensitization and Reprocessing

Bessel van der Kolk

Psychotherapy Networker magazine

In his 2014 interview, he said EMDR is superior to PE because EMDR helps people to “integrate the past” whereas PE only “desensitizes” people to their past. He said that PE “blasts people with the memory of their trauma and gradually you become numb to that particular memory. And so you don’t become quite as upset about remembering it as before. But the price of desensitization is you get desensitized for everything else as well…that’s not the same thing as healing. To numb yourself to stimuli means you don’t feel things anymore and that it’s likely that you won’t get upset when you perpetrate the behaviors on someone else. Desensitization is not the answer.”
https://www.youtube.com/watch?v=ELP_xhjjcaE

Treatment Misinformation

Therapists say:

"exposure is just desensitization, but EMDR heals the whole person."

"only a few failures out of hundreds of patients"

"EMDR is the only way to heal trauma"

- Patients feel hopeless or blamed when it fails

Zebra Trauma Therapy

Her therapists told her “EMDR is the only way to heal trauma”

She did not improve after fully dedicating herself to 5 months of EMDR: daily intrusions, nightmares, sleeping < 3 hours, actively suicidal). Her therapist repeated “we’ll just keep working at it.”

No alternatives to EMDR were ever mentioned. She believed failing EMDR meant she would have to endure PTSD symptoms for the rest of her life.

www.psychologytoday.com/us/blog/courage-heal

https://www.psychologytoday.com/us/blog/courage-heal

Psychology Today | Find a Therapist | Get Help | Magazine | Today

Find a Therapist (City or Zip)

Courage to Heal

Getting past trauma, suicidality, and borderline personality disorder.

Milton Z. Brown Ph.D.

Can People Have PTSD Without Even Knowing It?

Post-traumatic stress disorder can be insidious. Even if you do well in life, buried childhood memories can cause lifelong suffering and resurface years later.

Courage to Heal

Getting past trauma, suicidali
borderline personality disord

Milton Z. Brown, Ph
licensed clinical psy
professor, and direc
Dialectical Behavior
Center of San Diego

PTSD Treatment Options

Evidence-based therapies are very effective.
No evidence effectiveness differs.

Start with therapy the patient prefers.
After one fails, encourage patient to try another

Get Over It

- Approach over and over again
- Repeat avoided behaviors
- Stay with it for a long time
- “Revisit” the worse trauma memories, thoroughly, vividly, and repeatedly

Facing Avoided Situations

Facing Avoided Situations

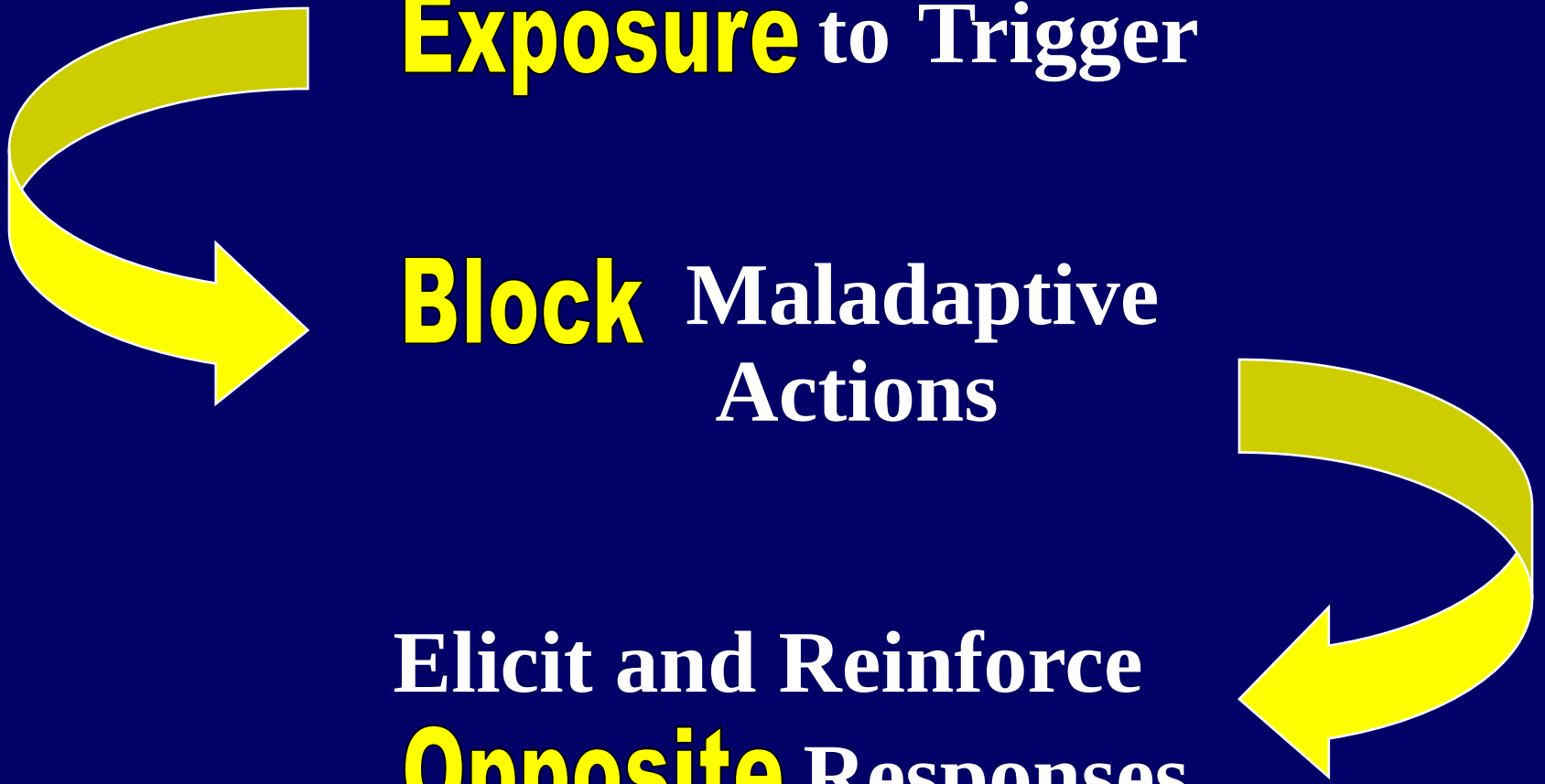
Facing Avoided Situations

Where the loss occurred (on fourth floor)

Facing Traumatic Memories

Facing Distressing Imagery

Opposite Action for Unjustified Emotions



“Lean in” to what you avoid

DBT for C-PTSD

To reduce treatment failures:

- Build more commitment and motivation
- Provide BPD-specific elements (validation and biosocial theory)
- Provide more structure
- Provide more comprehensive interventions
- Provide more therapy
- More thoroughly target shame and guilt

DBT for C-PTSD

DBT-PE (Harned)

- full standard DBT for one year (S-DBT)
  - 2 hours of skills group per week
- started prolonged exposure after 22 weeks
- 13 sessions of PE, 2 hours/wk of individual

DBT-PTSD (Bohus)

- 40-45 sessions
- started exposure after 18 sessions
- no therapy groups

DBT for C-PTSD

- DBT-PE had 80% PTSD recovery rate (vs. 40% for S-DBT) – both groups got one year of standard DBT
  - 40% dropped out early
  - big reductions in self-injury (more than S-DBT)
- Residential DBT-PTSD 41% recovered (70% improved) vs. 0% in Usual Residential TAU
- Outpatient DBT-PTSD had 58% PTSD recovery rate vs. 41% for CPT
  - dropouts: 25% (DBT-PTSD) vs. 39% (CPT)
  - big reductions in self-injury (more than CPT)

DBT-PE (Harned)

Exposure starts after proof of skills/readiness

- not at imminent risk of suicide
- no suicide attempts or NSSI in past 2 months
- able to control intentional self-injury when in the presence of triggers
- No serious therapy-interfering behaviors
- PTSD was the highest priority for patient
- able and willing to experience intense emotions without escaping

Exposure in DBT

- In vivo exposure
- Imaginal exposure
  - start with worst trauma memory
  - write trauma story
  - speak trauma story
  - visualize trauma story (eyes closed)
- Sessions end with "processing" conversations

DBT-PTSD (Bohus)

- Commitment (5 sessions)
- Motivation and Planning (7 sessions)
- DBT Skills (4-7 sessions)
- Exposure (15 sessions)
- Radical Acceptance (2 sessions)
- Regain Your Life (8 sessions)
- Farewell (1 session)

The Central Dialectic
Acceptance and Change

- BPD clients often feel invalidated when:
  - others focus on change (they feel blamed)
  - others offer too little help for change
- Balance therapist strategies
  - support, validation, and Rogerian skills
  - CBT: problem-solving, skills, exposure, cognitive restructuring, contingency management

The Central Dialectic
Acceptance and Change

- Only striving for (and insisting on) change is doomed to fail
  - blocking emotions perpetuates suffering
  - disappointed when not enough change or too slow
- BPD clients need to:
  - build a better life and accept life as it is
  - feel better and tolerate emotions better

DBT Is for Difficult Clients

- Numerous serious problems
  - multiple disorders (“BPD” and “bipolar”)
  - suicidal behavior and nonsuicidal self-injury
  - destructive behaviors; self-sabotage
- Severe emotion dysregulation and avoidance
  - severe shame and self-hatred
- Too many therapy-interfering behaviors
  - non-compliance
  - therapists and clients react strongly to each other

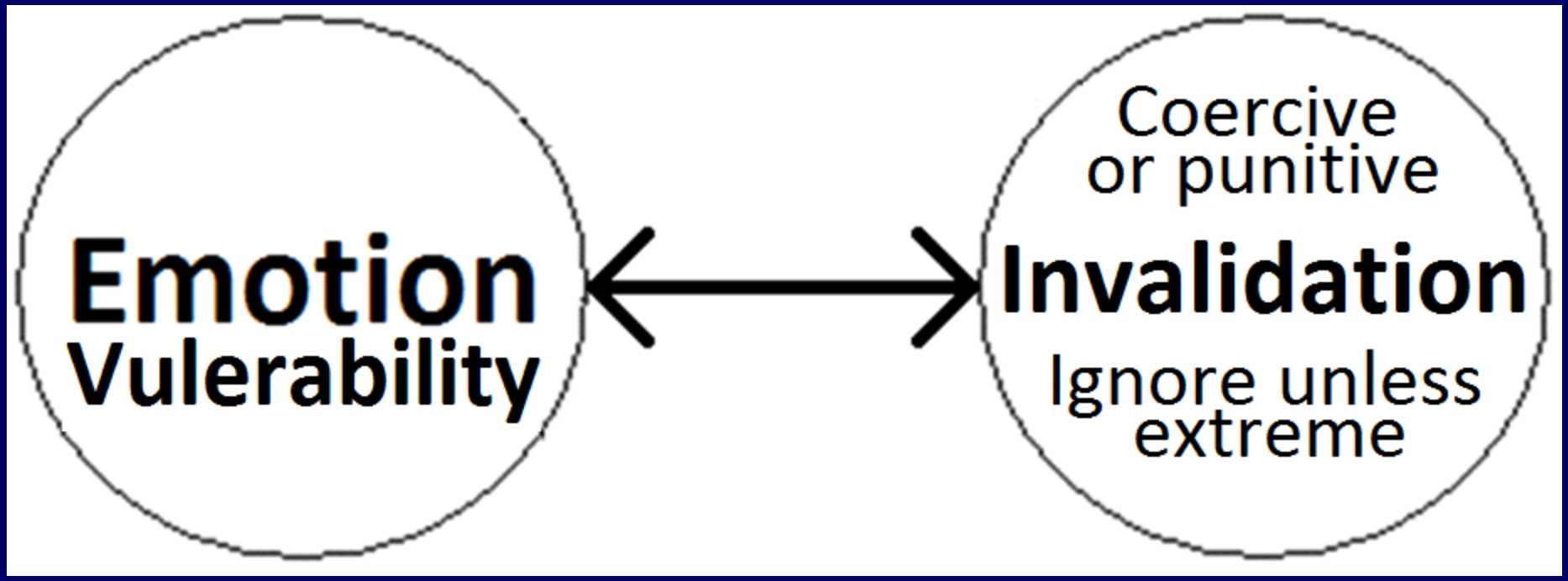
DBT Targets

- Serious problem behaviors targeted immediately and directly
  - suicidal behavior and nonsuicidal self-injury
  - excessive hospitalization
  - therapy-interfering behaviors
- Start with stabilization (coping skills)
  - reduce life chaos (problem solving)
  - build structure (e.g., work)
  - distraction and emotion regulation

DBT Components

- Individual therapy
- Phone calls for skills coaching
- Skills training group
- Therapist consultation meeting

Development of BPD



Levels of Validation

- Listen and pay attention
- Show you understand
  - paraphrase what the client said
  - articulate the non-obvious (mind-reading)
- Describe how their behaviors/emotions…
  - make sense given their past experiences
  - make sense given their thoughts/beliefs/biology
  - are normal or make sense now
- Communicate that the client is capable/valid
  - actively “cheerlead”
  - don’t treat them like they’re “fragile” or a mental patient

Validation

What ("yes, that's true" "of course")

- Emotional pain "makes sense"
- Task difficulty "It IS hard"
- Ultimate goals of the client
- Sense of out-of-control (not choice)

How

- Verbal (explicit) validation
- Implicit validation
  - acting as if the client makes sense
  - responsiveness (taking the client seriously)

Theory of BPD
Core Problem: Emotion Dysregulation

- pervasive problem with emotions
- high sensitivity/reactivity (i.e., easily triggered)
- high emotional intensity
- slow recovery (return to baseline)
- inability to change emotions
- inability to tolerate emotions (emotion phobia)
  - vicious circle (upward spiral)
  - desperate attempts to escape emotions
  - vacillate between inhibition and intrusion
  - inhibited grieving
  - history of invalidation for emotions
  - self-invalidation and shame
- inability to control behaviors (when emotional)

Principles of DBT

Functions (overview):

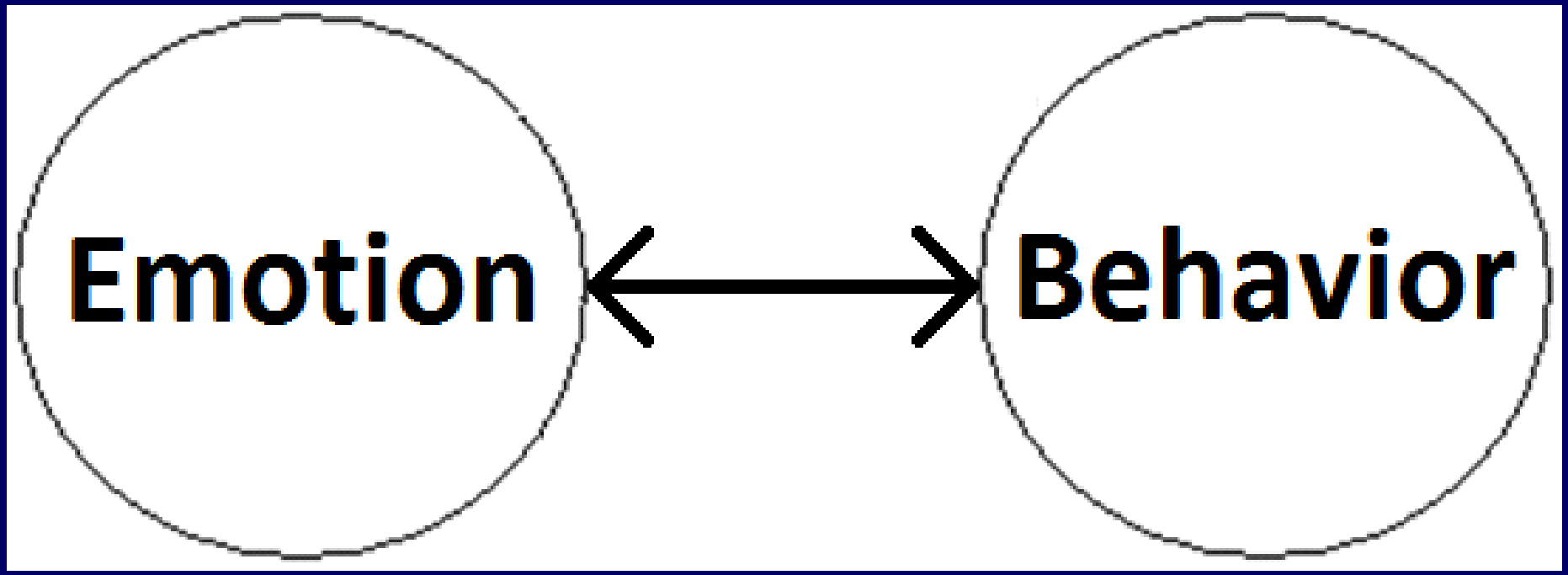
- Enhance capabilities
- Emotion regulation*
- Activate behavior
  contrary to emotions
- Enhance motivation
- Structure environment
- Assure generalization
- Help therapists

Principles of DBT

Functions (overview):

• Enhance capabilities	Skills Training
• Emotion regulation*	
• Activate behavior	Behavioral Activation
contrary to emotions	Opposite Action
• Enhance motivation	MET
• Structure environment	Reinforcement
• Assure generalization	Phone Coaching
• Help therapists	Consultation Meeting

Behavioral Theory



Improving emotion-driven behaviors improves emotion functioning
Improving emotion functioning improves emotion-driven behaviors

Emotion Regulation Skills

- Mindfulness
- Distress Tolerance
  - surviving crises
  - accepting reality
- Emotion Regulation
  - reduce vulnerability
  - reduce emotion episodes
- Interpersonal Effectiveness
  - assertiveness

Assess Triggers / Behaviors

Interview: triggers (cues), emotion-driven behaviors (avoidance), safety behaviors

Questionnaires

In vivo assessment

Self-monitoring of triggers and EDB

Reactions during exposure

- observe spontaneous responses
- ask about “hot spots” and thoughts

Assessment Interview

- What are your current triggers
  - What do you do to get through it?
- What would trigger you?
  - excessive reactions? worst-case scenario
- What do you (would you) avoid?
- What do you not do because of your…?
- What do you avoid because of your…?
  - Which are unnecessary (actually safe)?
  - Which do you most desperately avoid?

Assessment Interview

- What do you feel keeps you safe?
- How do you minimize distress tied to your PTSD, worry, shame, etc.?

- Brainstorm possible evocative tasks
  - places, people, images, sounds, scents, tactile feelings, internal physical sensations

- When they refuse ask “Why not?”
  - Do “downward arrow” assessment of fears

Exposure Rationale

- Cover basic content in my first 11 slides
- Brain tricks us into being overly fearful
  - protects us by overgeneralizing perceived danger
  - reminders, memories, and images seen as dangerous
- Desensitize and safety learning
  - need convincing information from a new experience
  - need enough time for safety info to “sink in” to the gut
- Practice tolerating or coping with triggers
- We can “act into” new emotions
- Teach parents to give rationale to teens

Session Structure

Before an exposure:

- What do you expect? (worst-case scenario)
- How strong is belief? (% likelihood)
- How long will you be able to continue?

During an exposure:

- belief strength (%) and tolerance ratings
- Look for “hot spots” (nonverbal clues)

After an exposure:

- What did you learn during this exposure?

Session Structure

After an exposure:

- What did you learn?
- What were the “hot spots”? What thoughts were you having during the hot spots?
- How did you get through it? How did you keep yourself safe?
- Were SUDS high? Why not?
- Did it prove you are safe? Any “What if?”
  – downward arrow
- Sleep soon to consolidate learning

Exposure Failures

- Not enough exposure
- Potent triggers are missing
  - too narrow (missing external or internal)
  - missing core fear (catastrophe)
  - weak stimuli (not accurate or vivid)
- Poor generalization (spontaneous recovery)

Multimodal Exposures

before/during/after imaginal or in vivo

- evocative music, scents, touch, tastes
- look at relevant photos and videos

Imagery exposure during in vivo exposure

- hear trauma scripts at trauma locations
- listen to 911 calls (driving or PTSD)
- listen to gun fire and explosions (PTSD)

Promote Generalization

- Variable contexts
  - audio recordings of sessions
  - more exposure homework (variety)
- Variability of exposure content
- Extinction reminders (retrieval cues)
- Remove safety signals (depends on)
  - paced breathing
- Multimodal exposures (combine cues)

Variability

Contexts

- Different therapists, family, alone
- Different rooms, and outdoors
- At trauma locations
- Day and night
- Different combinations
- In different orders (tasks, objects, scripts)

Scripts

- Client reads and listens to recording
- Therapist reads

Multimodal Exposures

Induce sensations

- caffeine
- vigorous exercise (heart rate or shaking)
- spinning or head rolling (dizziness)
- breathe through a straw
- hyperventilate
- swallow quickly
- cigarette withdrawal

before/during imaginal or in vivo exposure

Multimodal Exposures

After inducing sensations:

- read trauma script (PTSD)
- interact with strangers (fear of humiliation or rejection)
- enter a feared setting (movie theater, tall building, elevator)
- say taboo thoughts (OCD)

Not Enough Exposure

- Excessive non-compliance
- Avoidance to exposure ratio
  - anti-anxiety meds after distress
  - enabling (mother pushed meds)
- Emotion escape after exposure
  - prescribed meds
  - substance use
  - self-injury
  - relaxation

Missed Core Triggers

- Not enough focus on hot spots (“diluted”)
  - What parts were the most distressing?
  - What about it? What were your thoughts?
- Missed some core fears
  - more catastrophe questions and hypotheses
  - What’s the worst thing that could happen?
  - “Glad I didn’t have to…”
  - brainstorm possible tasks and ask “What would it be like to do that?”
  - More “downward arrow” assessment

Vivid/Accurate Stimuli

Personal or online photos?
Online videos or movies?
Can sounds be recreated? train, steps
Physical props? pool stick, clothing, scent
Can physical sensations be recreated?

- car movement and sounds
- touch

Vivid/Accurate Stimuli

"Imagine your mother invalidating you"
"Imagine your mother saying that she will give you something to cry about"
Therapist: "You better stop that Mindy, or I'll give you something to cry about"

Most effective to hear mother say:
"I'll give you something to cry about"

Non-compliance

- Re-orient and re-commit
  - review rationale and goals
  - “downward arrow” assess refusal
- Start with smaller in vivo tasks
  - imagery first
- Therapist more practical homework help
  - more homework prompts and calls
  - verification texts to therapist

Skills for Reducing Behavior

- Pros/Cons of new behavior
- Mindfulness of current emotion/urge
- Postpone behavior for a specific small amount of time (fully commit)
  - Distract, relax, or self-soothe
  - Postpone behavior again
- Do the behavior in slow motion
- Do the behavior in a very different way
- Add a negative consequence for behavior

Skills for Reducing Emotions

- Temperature
  - ice cubes in hands*
  - face in 45º water, cold packs, whole body dunk (BF)
- Intense exercise
- Progressive muscle relaxation
  - progressive muscle relaxation
- Slow diaphragmatic breathing
- Distraction
  - activities with focused attention
  - self-soothing

When the Japanese mend broken objects, they aggrandize the damage by filling the cracks with GOLD.

They believe that when something's suffered damage and has history it becomes more beautiful.

Bohus, M. et al. (2020) DBT for PTSD compared with cognitive processing therapy in complex presentations of PTSD in women survivors of childhood abuse. *JAMA Psychiatry*, 77(12).

Bohus M, (2013). DBT for PTSD after childhood sexual abuse in patients with and without BPD: a randomised controlled trial. Psychotherapy and Psychosomatics, 82(4).

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