BEHAVIORAL RESEARCH & THERAPY CLINICS
UNIVERSITY of WASHINGTON
Center for Behavioral Technology

TREATING PTSD DURING DIALECTICAL BEHAVIOR THERAPY

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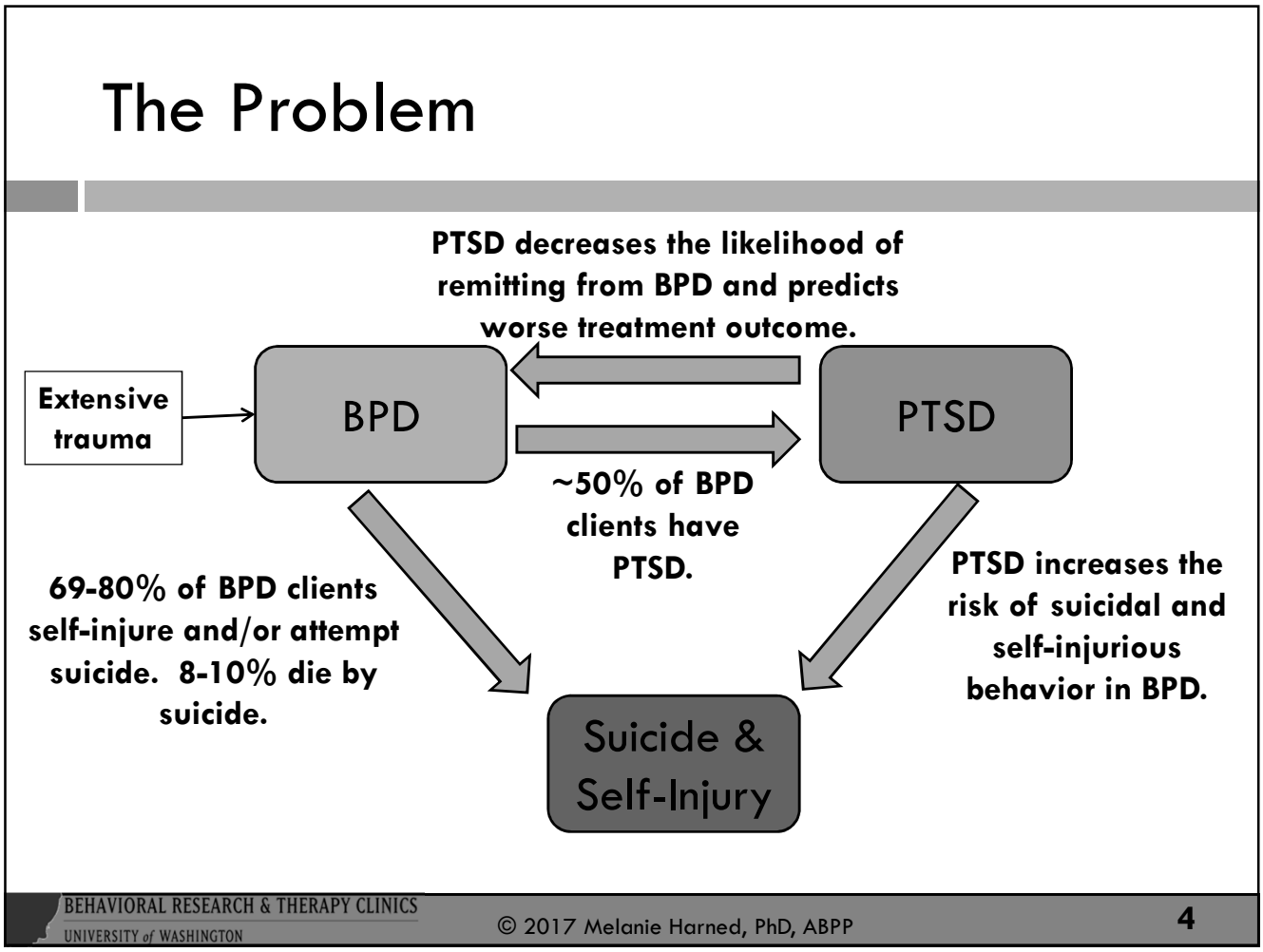
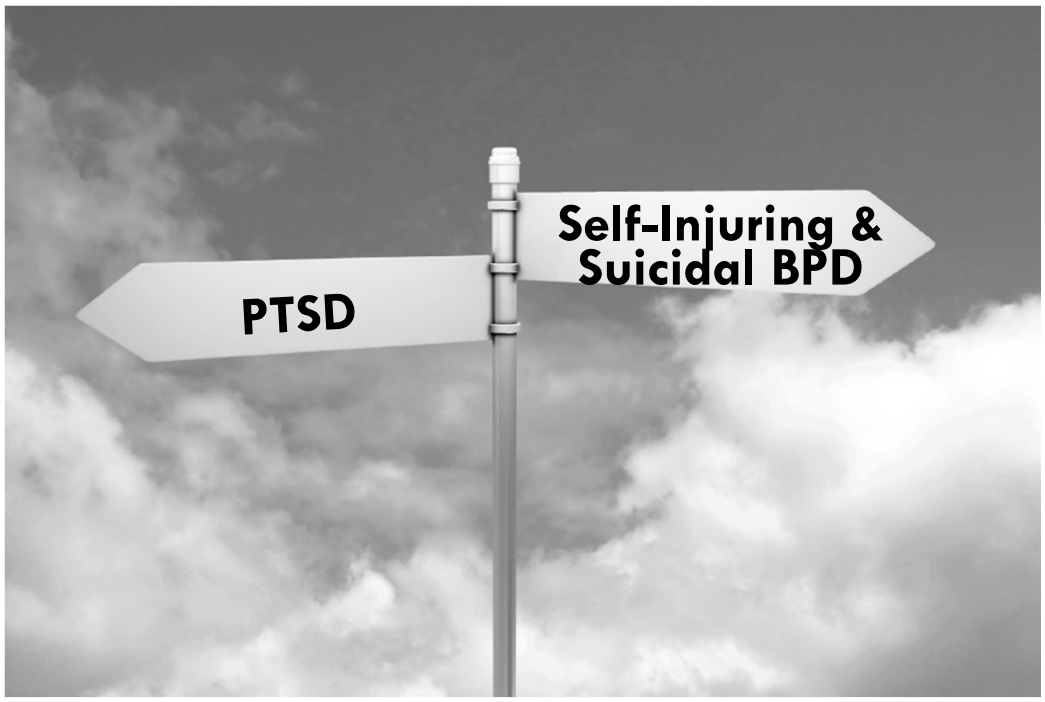
Disclosures

- Dr. Harned
  - Receives federal grants to research DBT and DBT PE
  - Is paid to provide training and consultation in DBT and DBT PE

Why is this Treatment Needed?



Existing Standard of Care



PTSD Treatments: The Problem of Exclusion

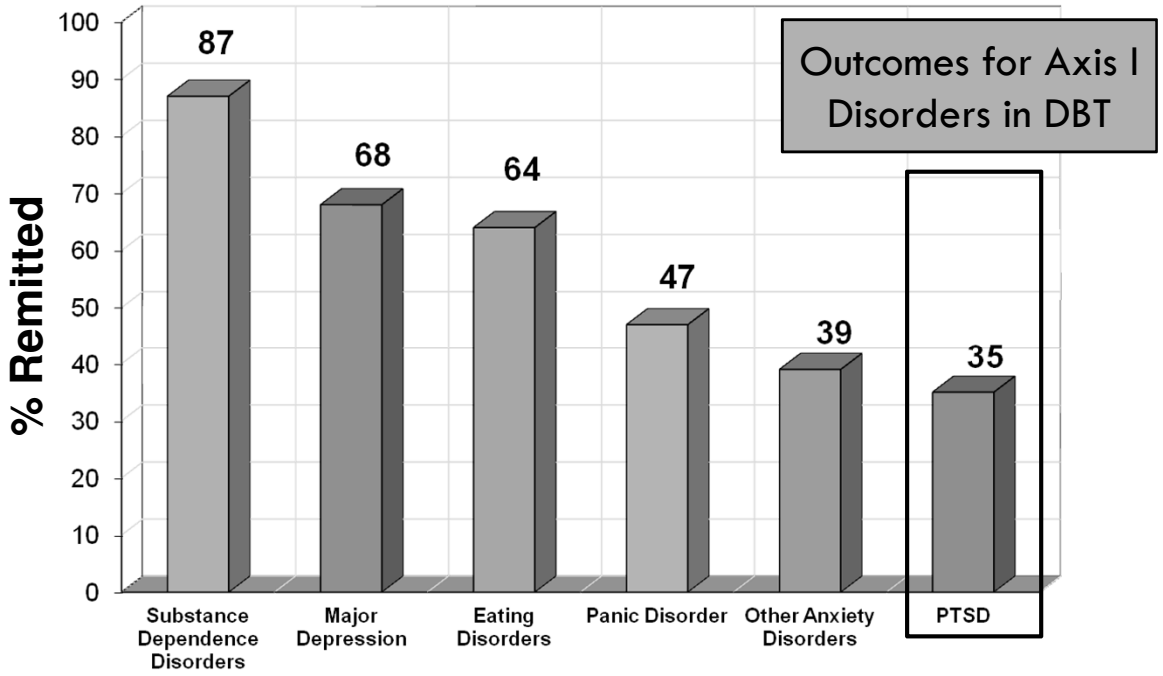
- Clinical trials for PTSD have excluded ~30% of patients referred for treatment.
- The number of exclusion criteria used is positively related to outcome.
- Common exclusion criteria:
  - Suicide risk and self-injury
  - Substance abuse/dependence
  - Psychosis
  - Serious comorbidity

"[T]he common confluence of exclusion criteria for suicide risk and substance abuse/dependence is likely to exclude many patients with borderline features…"

(p. 224)

BRADLEY, GREENE, RUSS, ET AL.
Am J Psychiatry 162:2, February 2005

DBT: The Problem of not Targeting



(Harned, Chapman, Dexter-Mazza, Murray, Comtois, & Linehan, 2008)

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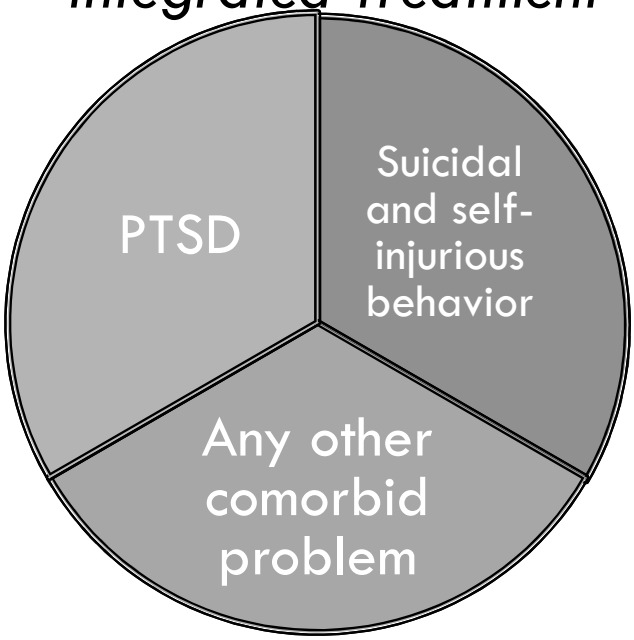
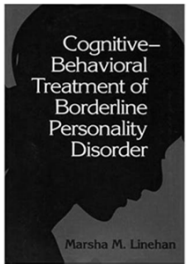
A New Standard of Care

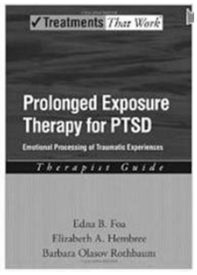
Integrated Treatment



Integrating DBT with Prolonged Exposure therapy for PTSD



- Standard DBT (1 year)
  - Individual DBT therapy (1 hour/wk)
  - DBT group skills training (2.5 hours/wk)
  - Telephone coaching (as needed)
  - Therapist consultation team (1 hour/wk)



- DBT Prolonged Exposure Protocol
  - Modified Prolonged Exposure therapy for PTSD
  - Occurs concurrently with standard DBT
  - Administered by the individual DBT therapist

DBT PE Protocol Treatment Structure

- Pre-exposure (2-3 sessions)
  - Orienting, trauma assessment, psychoeducation, in vivo hierarchy, commitment strengthening, and skills plan
  - Joint session with support person(s) (optional)
- Exposure sessions (flexible number of sessions)
  - In-session: imaginal exposure and processing
  - Homework: in vivo and imaginal exposure
- Final session(s) (1-2 sessions)
  - Brief imaginal exposure
  - Relapse prevention, consolidation, review of progress

All Core PE Treatment Strategies are Used

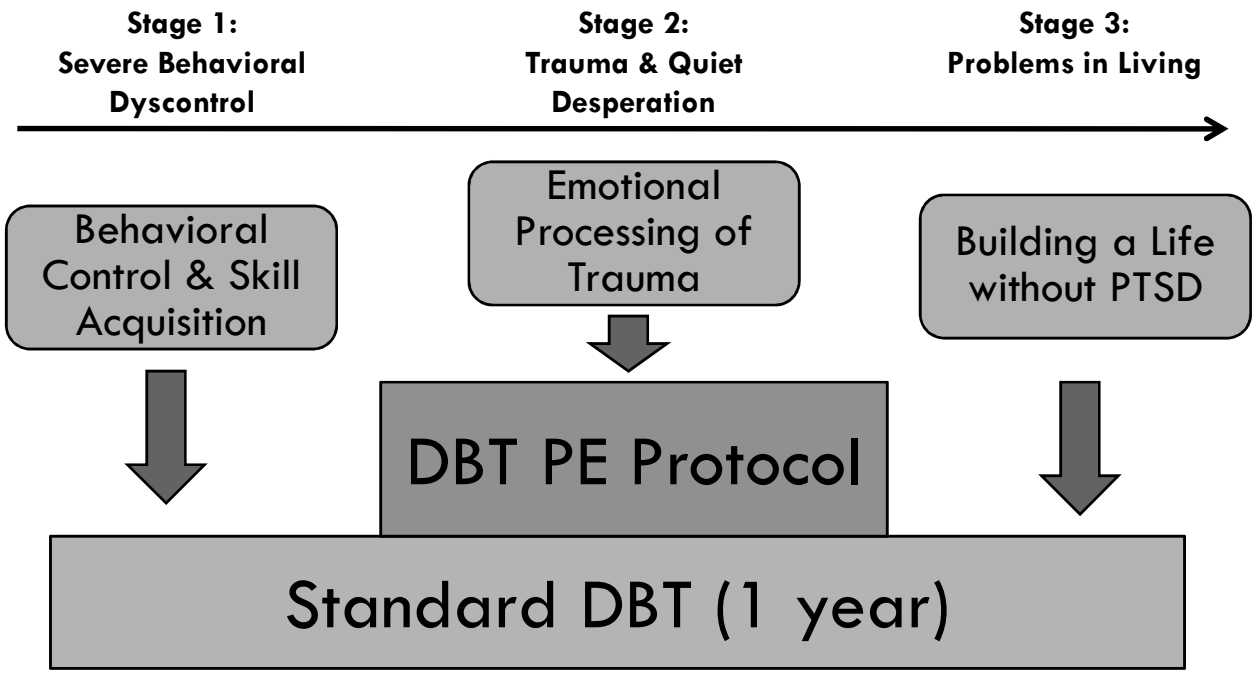
The Treatment Development Process

Problems to Solve

1. Suicide risk and other high-priority problems made targeting PTSD untenable.

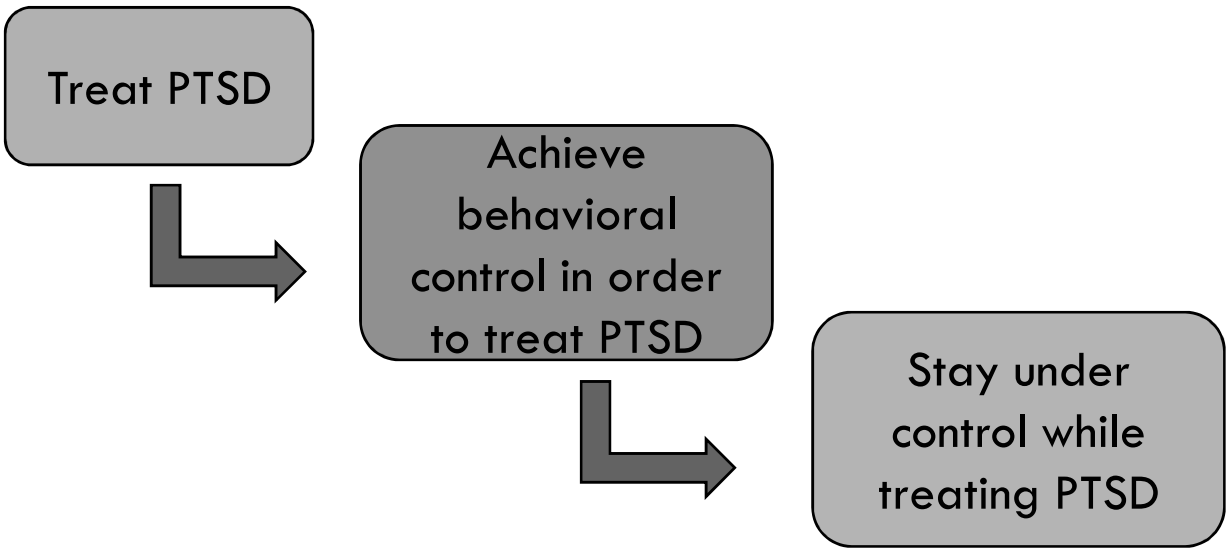
2. Poor distress tolerance made exposure therapy also untenable.

Solution Was to Use a Stage-Based Treatment Model



Solution Was Also to Apply

- DBT contingency management and commitment strategies to increase motivation to:



Problems to Solve

3. No clear criteria existed for determining when suicidal and self-injuring BPD clients are ready for PTSD treatment.

Solution Was to Develop

BPD-specific readiness criteria

and

Test them through an iterative process of treatment development

Deciding when to Start PTSD Treatment

- Not at imminent risk of suicide.
- No recent (past 2 mos.) life-threatening behavior.
- Ability to control life-threatening behaviors in the presence of cues for those behaviors.
- No serious therapy-interfering behavior.
- PTSD is the highest priority target for the client and the client wants to treat PTSD *now*.
- Ability and willingness to experience intense emotions without escaping.

Problems to Solve

4. Therapists were sometimes afraid to treat PTSD, even when clients were eligible.

Solution Was to Use

- DBT Therapist Consultation Team to assess and problem-solve therapist factors that interfere with PTSD treatment:
  - Fear of making the client worse
  - Uncertainty about client readiness
  - Lack of confidence in ability to treat PTSD
  - Burnout

Problems to Solve

5. PE does not include structured methods for monitoring suicide risk and other potential negative reactions to exposure.

Solution Was to Apply

DBT Self-Monitoring Strategies

DBT Diary Card

- ✓ Suicide attempts
- ✓ Self-injury
- ✓ Urges to commit suicide
- ✓ Urges to self-injure
- ✓ Substance use
- ✓ Other client-specific problem behaviors

Pre-Post Exposure Ratings

- ✓ Urges to commit suicide
- ✓ Urges to self-injure
- ✓ Urges to use substances
- ✓ Urges to drop out
- ✓ Dissociation

Problems to Solve

6. BPD clients often have difficulty achieving effective levels of emotional engagement during exposure.

Solution Was to Use DBT Skills During Exposure As Needed to

Down-regulate Emotions	Up-regulate Emotions
☐ Opposite action ☐ TIPP skills ☐ Self-soothe ☐ Distraction ☐ IMPROVE the moment	☐ Observe and describe ☐ One-mindfulness ☐ Mindfulness of current emotion ☐ Mindfulness of thoughts ☐ Radical acceptance ☐ Willingness

Problems to Solve

7. BPD clients have multiple problems and chaotic lives that make focusing only on a single problem (or disorder) difficult.

Solution Was Also to Use DBT to Address

- Any other serious problems that may occur during PTSD treatment (whether or not they are related to PTSD treatment).
  - Increased suicide or self-injury urges or behaviors
  - Treatment noncompliance
  - Major life problems (e.g., relationship, employment, housing, financial, and health problems)
  - Other Axis I or II disorders (e.g., eating disorders, major depression, substance use disorders)

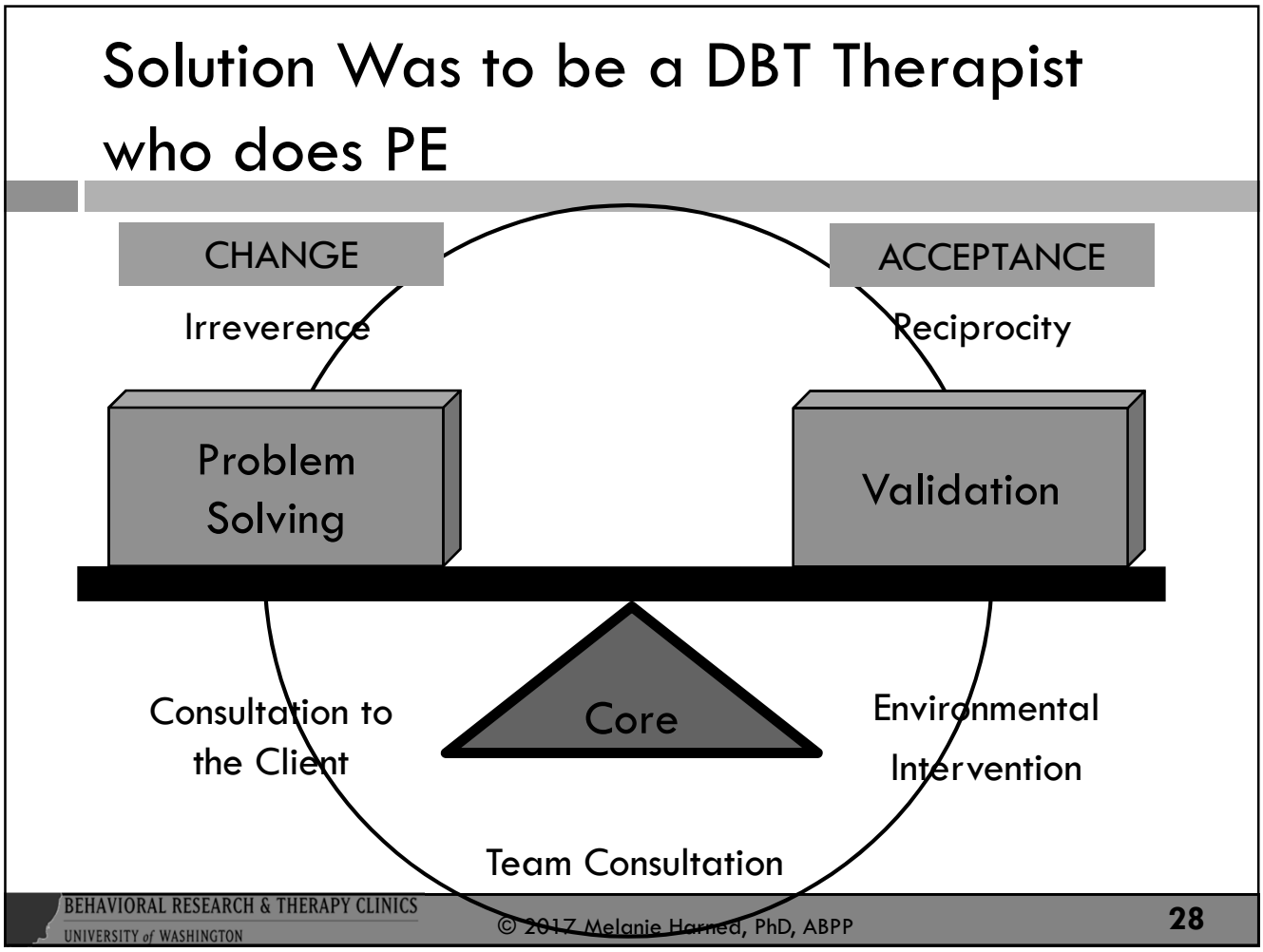
Use standard DBT strategies, skills, and protocols to target these problems, ideally without having to stop PTSD treatment.

Solution Was Also to Develop

- Specific guidelines for:
  - When to stop PTSD treatment
    - If higher-priority behaviors occur (or recur)
  - What to do while PTSD treatment is stopped
    - Targeting higher-priority behaviors
  - When to resume PTSD treatment after stopping
    - When higher-priority behaviors have been sufficiently addressed

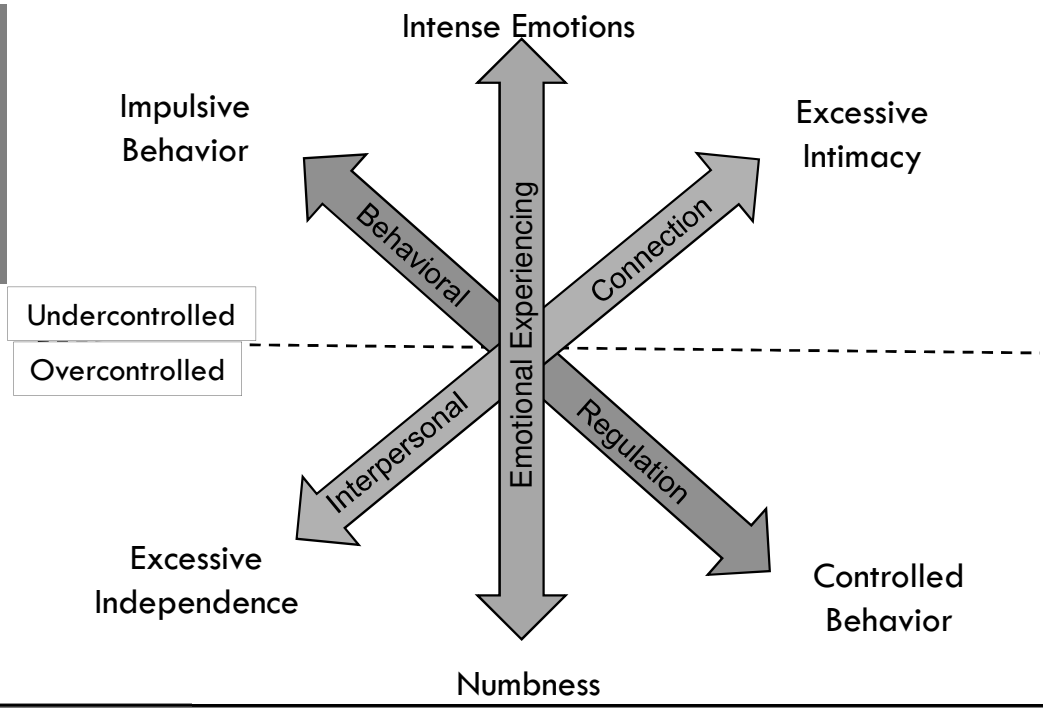
Problems to Solve

8. Some therapist strategies that are recommended in PE are:
   - Incompatible with DBT therapist strategies, *and/or*
   - Do not address the specific cognitive, emotional, and behavioral characteristics of severe BPD clients.



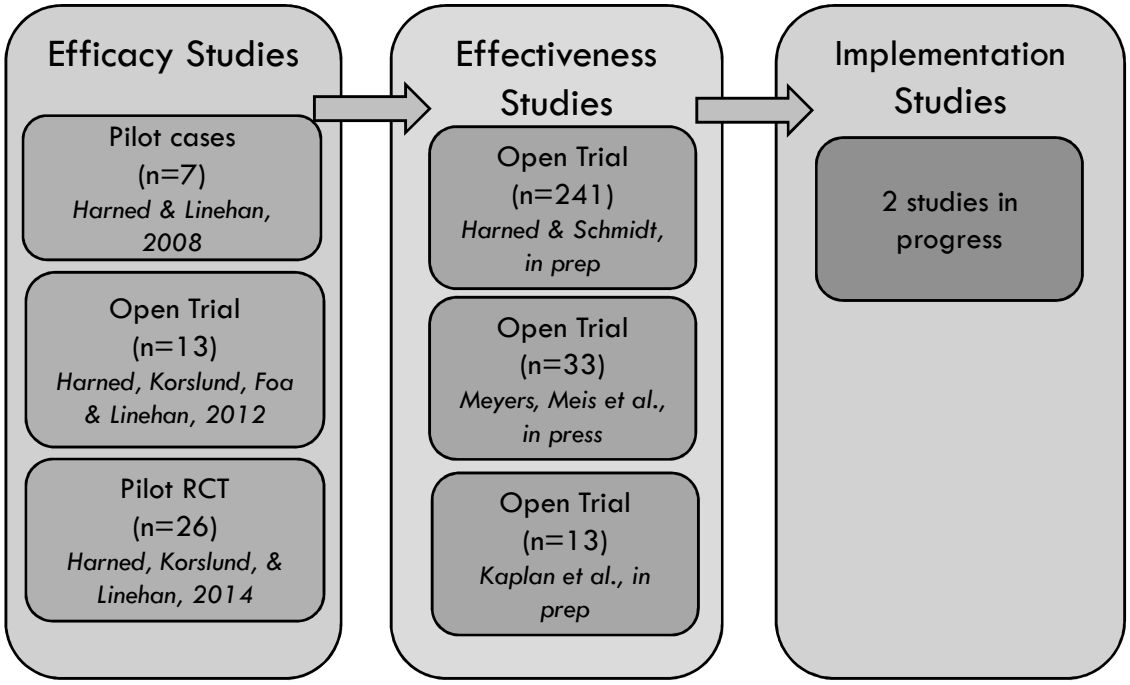
Solution was to Integrate DBT Principles into DBT PE

A Dialectical Framework for Trauma Reactions



Research Findings

Research Progress

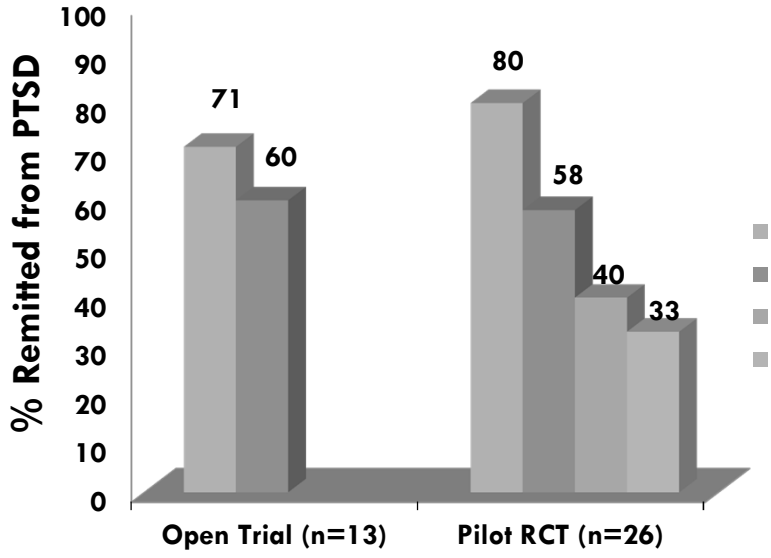


Acceptability and Feasibility

- 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)

(Harned et al., 2012; 2014)

PTSD Remission Rates at Post-Treatment



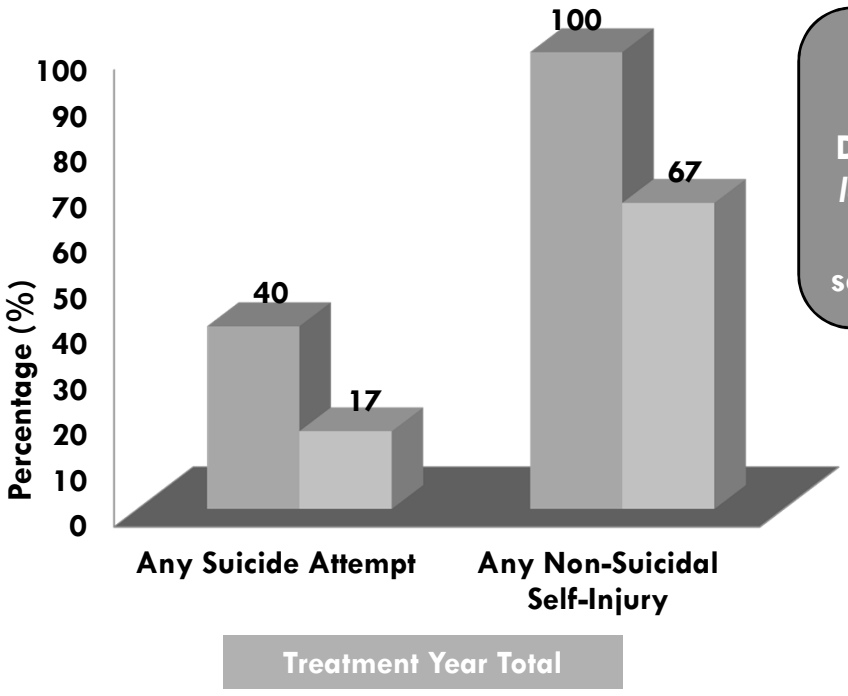
Meta-Analysis of Exposure Treatments for PTSD*

Completers: 68%

Full Sample: 53%

* Bradley et al., 2005

Suicidal and Non-Suicidal Self-Injury

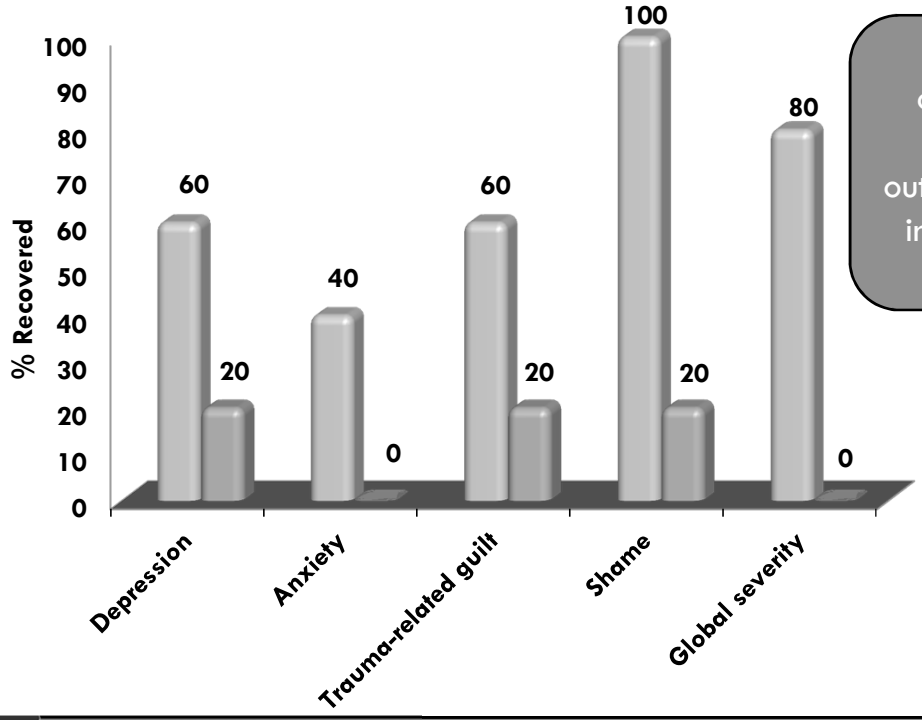


Among treatment completers, clients in DBT+DBT PE were 2.4 times *less* likely to attempt suicide and 1.5 times *less* likely to self-injure than those in DBT.

Treatment Year Total

Harned, Korslund, & Linehan, 2014

Secondary Outcomes: Recovery Rates



Among treatment completers, recovery rates on secondary outcomes were 40-100% in DBT+DBT PE and 0-20% in DBT.

DBT + DBT PE

DBT

Recovery = reliable improvement + normative functioning

(Harned et al., 2014)

Effectiveness Studies

Clients of Trained Community Clinicians (n=241) *(Harned & Schmidt, in prep)*	• PTSD "much improved" on average • No worsening of suicidal behavior
Veterans (n=33) *(Meyers et al., in press)*	• 64% were below clinical cut-offs for PTSD at post-treatment • Significant improvements in BPD, suicidal ideation, anxiety, depression
Adolescent Girls (n=13) *(Kaplan et al., 2017)*	• 69% completed treatment • Completers ended below clinical cut-offs for PTSD

Conclusions

DBT with the DBT PE protocol:

- ✓ Is feasible to implement for the majority of clients who complete one year of standard DBT.
- ✓ Can be delivered safely.
- ✓ Achieves rates of PTSD remission comparable to other PTSD treatments and higher than standard DBT.
- ✓ Is associated with large improvements in a variety of BPD and trauma-related outcomes that are greater than those found in standard DBT.
- ✓ Shows promise when implemented in community practice settings, including with men and adolescents.
- ✓ Can be effectively disseminated to community clinicians.