Integrating DBT and EMDR Therapies in Abuse and Trauma Recovery

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Abuse and Trauma

Hensley pp. 2-3

Trauma may diagnosed in the DSM-V as F43.10 PTSD, or as F 43.0 Acute Stress Disorder. Acute Stress Disorder is distinguished from PTSD in that symptoms must occur within one month of the traumatic event, and resolve within one month of the traumatic event. After one month, if symptoms are not resolved, the diagnosis is changed to PTSD.

Adults, Adolescents, and Children may be diagnosed with PTSD. The DSM-V lists specific criteria for diagnosing children 6 years or younger with PTSD (DSM-V pp. 272-273)

What is Abuse? It is…

Hensley pp. 2-3

- an action that intentionally harms or injures another person for self-gratification of the perpetrator's wants, beliefs, or urges
- may be physical, verbal, emotional, sexual, psychological, medical, and/or financial
- typically involves actions by a more powerful person towards a weaker one, such as child abuse, elder abuse, domestic abuse, sex trafficking, and abuse by a person in authority, e.g. an employer or law enforcement representative or entity
- it may be based upon hatred of a particular group, e.g. race, ethnicity, culture, religion, socio-economic status, political affiliation, gender, or sexual orientation
- Abuse may be traumatic, but not all traumatic events are due to abuse
- Some traumatic events are due to natural, work-related, or accidental events, and as such lack the volitional aspect of abuse

Trauma is…

Hensley pp. 2-3

- An event experienced or witnessed by a person, including vicarious trauma (e.g. watching 911 film clips on TV, clinicians who are repeatedly exposed to clients' trauma stories)
- May lead to:
  - Intrusive symptoms (flashbacks, somatic reactions, nightmares)
  - Avoidance of triggering situations, people, or events
  - Alterations in arousal and reactivity
  - Phobias, fears, and anxiety

Post Traumatic Stress Disorder

Shock Trauma: This diagnosis of PTSD refers to the symptoms that result when a person experiences a short-lived, single episode trauma.

Examples:

- Serious accidents: automobile, boating, airplane, bike, near drowning
- Natural disasters: hurricanes, forest fires, tornados, floods, earthquakes, avalanches, blizzards, volcanic eruptions
- Physical and sexual assaults, including those that may lead to disfigurement (slashing, acid attacks, burning) or life altering after affects (pregnancy, STDs, cultural rejection)
- Acts of terrorism: bombs, kidnapping, 911
- Major life changes: serious illnesses, loss of loved ones
- Major surgeries: cancer, heart attacks, craniotomies, heart bypass)

(Hensley, pp. 4-5)

Post Traumatic Stress Disorder

Characteristics:

- The event is normally seen as traumatic
- Most often there are intrusive images
- Elicits negative beliefs, emotions, and physical sensations
- Lasting effects on the client's sense of safety in the world

Work related complex trauma:

- Combat troops
- First Responders: EMTs, Firefighters, Police officers, ER staff, Security industries
- Sexual harassment, hostile work environments
- Journalists, reporters, media professionals exposed to natural disasters, homicide, suicide, war, terrorism, traumatic accidents

Developmental of Complex Post Traumatic Stress Disorder

Hensley pp.4-5

Chronic traumas:

- Continue for months or years at a time
- Current PTSD diagnosis often does not capture the severe psychological harm that occurs with such prolonged, repeated trauma or distressing life events

Characteristics:

- May not be perceived as disturbing at the time
- More common and ubiquitous, usually accumulating over time from childhood
- More often pervasive and ongoing
- Often there is no intrusive imagery
- Lasting negative beliefs, emotions, sensations, and effects on the client's self-esteem
- Environment fails to provide healthy role models for developing effective coping skills, which sets the stage for addictions, self-destructive behaviors, and unhealthy relationships

Developmental or Complex Post Traumatic Stress Disorder

Hensley pp.4-5

Helplessness: The victim is held in a state of captivity. In these situations the victim is under the control of the perpetrator and unable to flee (Judith Herman).

- Concentration/prisoner/of war camps, refugee camps
- Prostitution brothels, sex trafficking, organized child exploitation rings
- Child/youth sexual abuse, both incest and authority figures (coaches, clergy, teachers, child care providers, neighbors, etc.)
- Long-term domestic violence, severe physical abuse, severe emotional abuse
- Kidnapping, i.e. Elizabeth Smart, Shawn Hornbeck (Michael Devlin)
- Dangerous or stressful living environments: war zones, high crime areas, high poverty areas

Abuse and Trauma

Hensley pp. 2-3

Can contribute to:

- Irrational and/or negative beliefs (People are out to get me, All men are untrustworthy, My needs are not important, I have to take care of others, I have to be perfect, I can never please people, Something bad always happens to me)
- Negative emotions, personality and mood disorders (depression, anxiety, complex bereavement, explosive anger, BPD, Dependent Personality Disorder, Dissociative Disorders)
- Negative impact on self-efficacy and self-confidence (I can never succeed)
- Feeling "frozen" or "stuck" in a memory network and/or a developmental state

Developmental or Complex Post Traumatic Stress Disorder

Hensley pp.4-5

Examples:

- Moving multiple times during childhood
- Death or loss of a loved one, either familial or friend
- Excessive teasing and bullying, including cyber
- Death of pets
- Getting lost
- Persistent physical illness

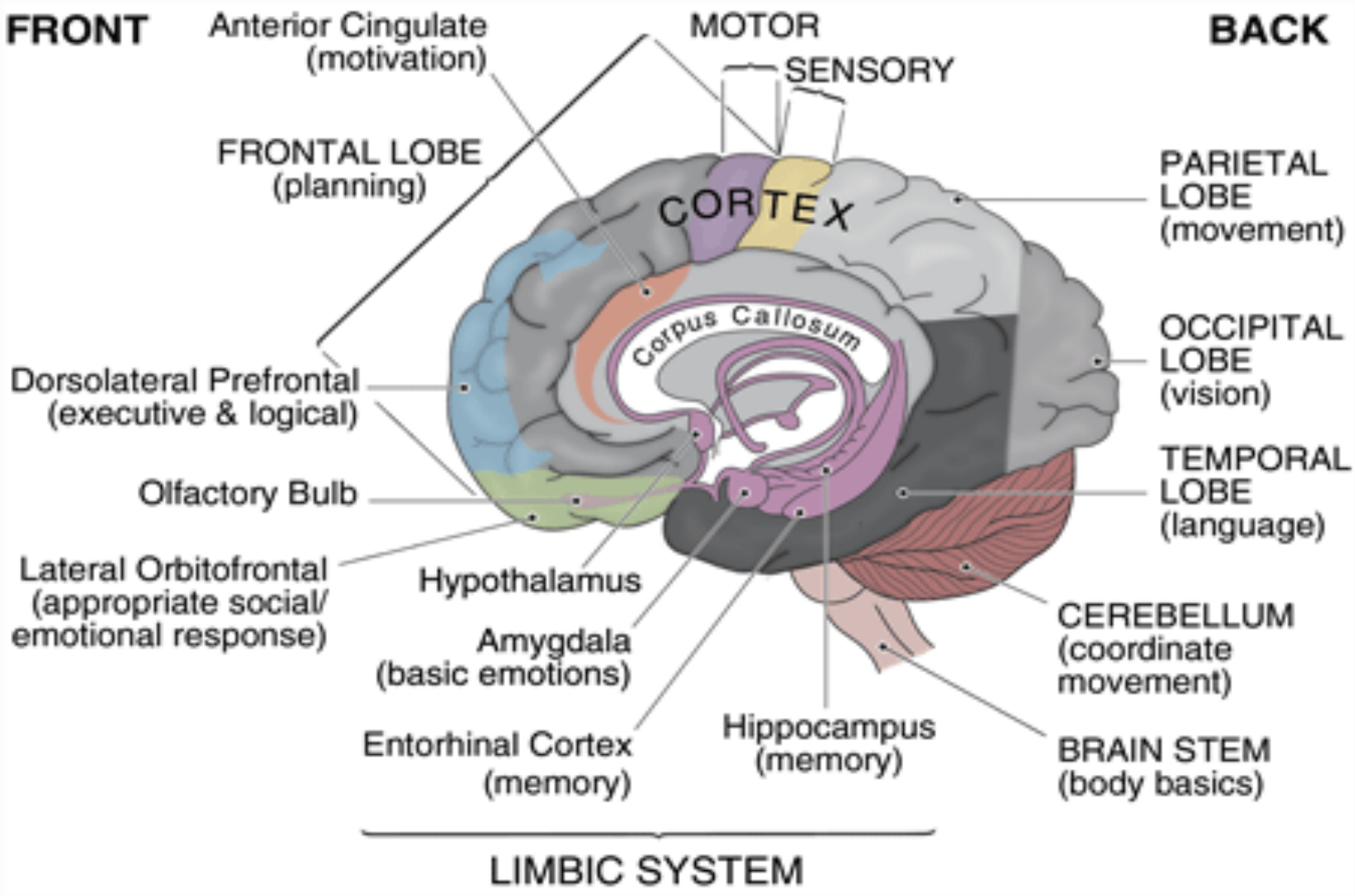
Developmental or Complex Post Traumatic Stress Disorder

Hensley pp.4-5

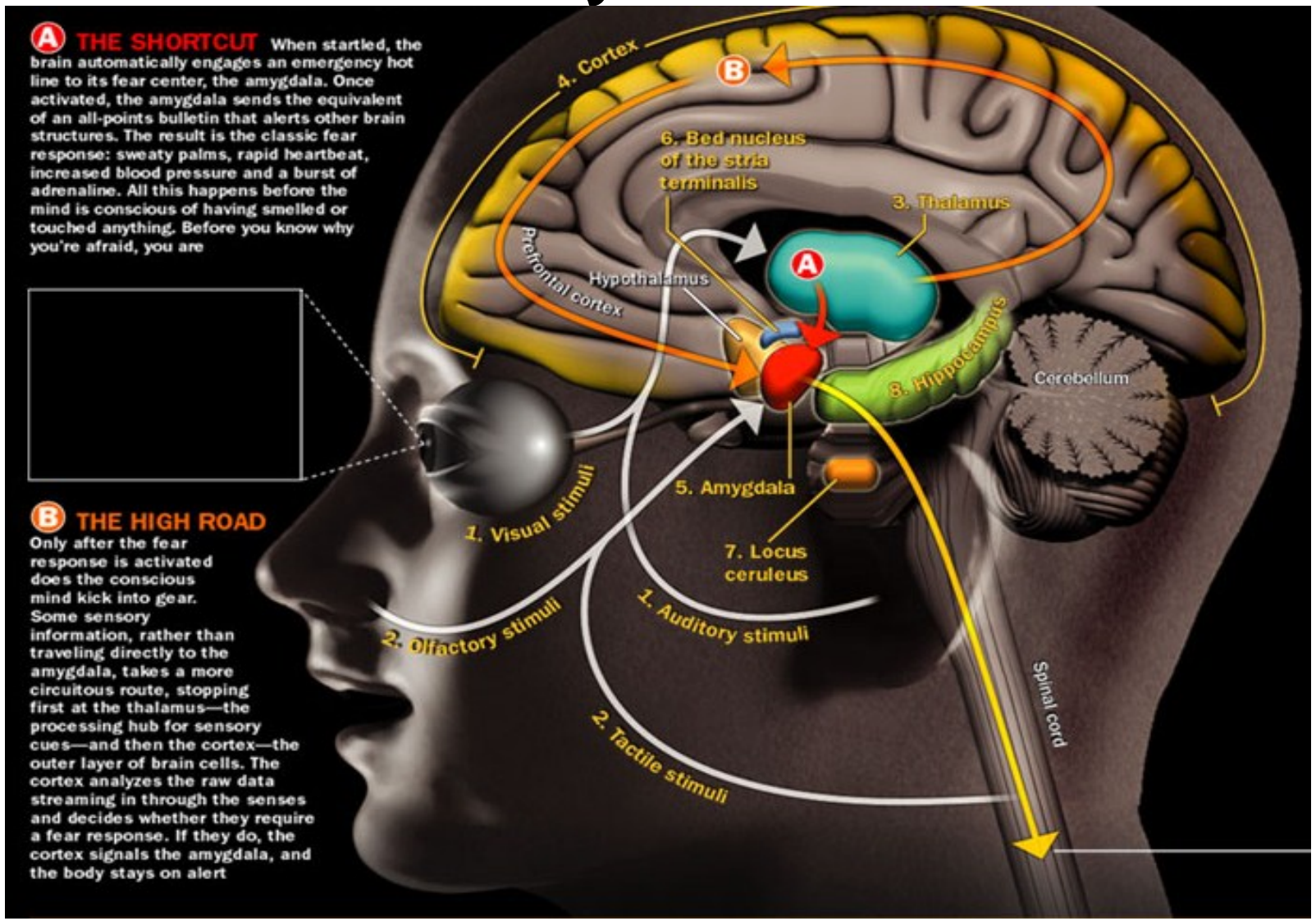
Examples:

- Persistent physical illness
- Divorce or witnessing parental conflict
- Rejections and betrayals
- Constant criticism
- Public shaming, humiliation, or failure
- Financial or status losses

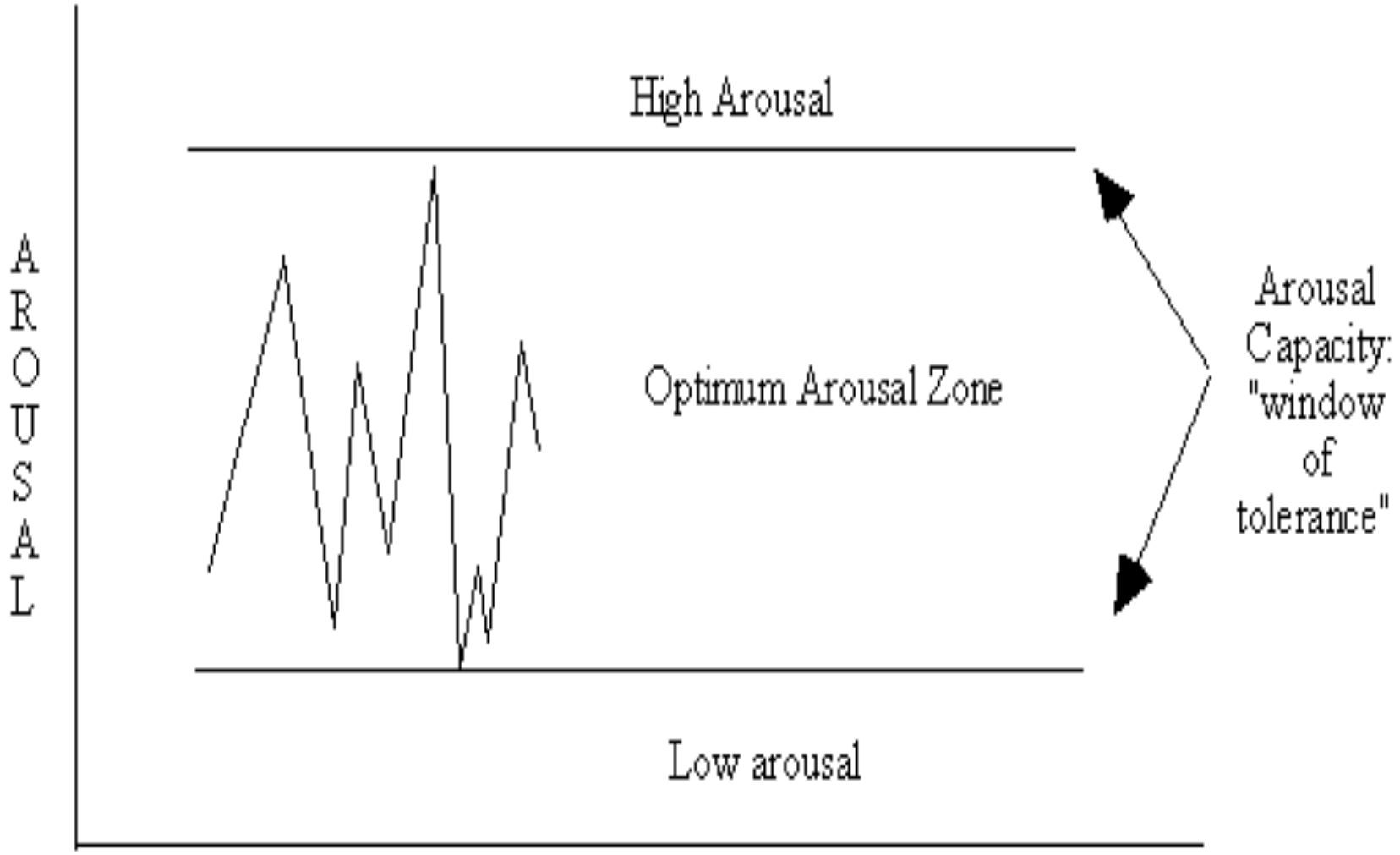
The Limbic System



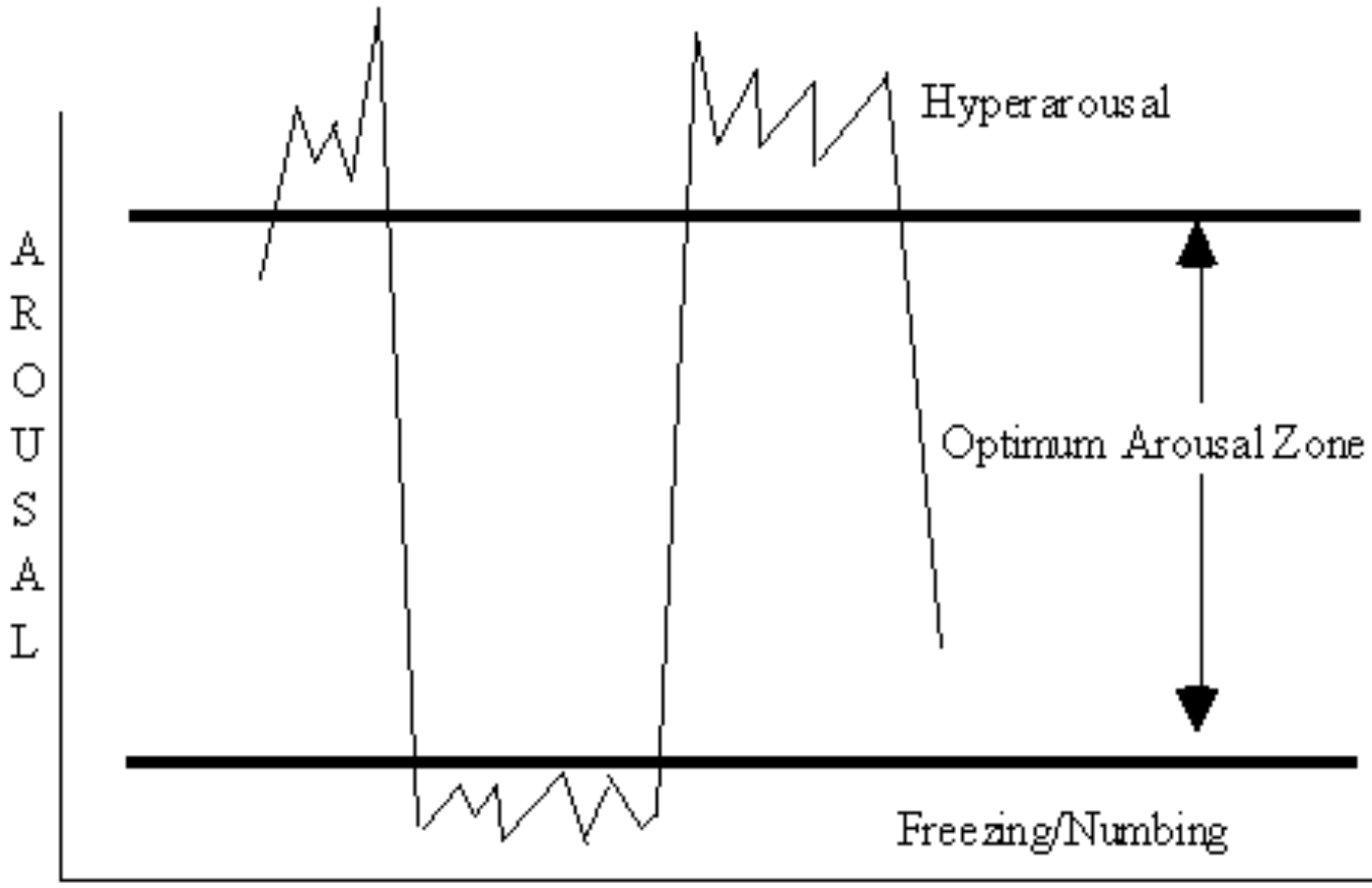
Two Pathways



Optimal Arousal Zone



Arousal Zones:
Bi-Phasic Response to Trauma



Dialectical Behavior Therapy (DBT)

- Marsha Linehan, PhD. (Univ. of Washington) 1980's
- Empirically supported, evidenced based treatment
- Borderline Personality Disorder (BPD)
- High levels of suicide, self-injurious behaviors, depression, frequent and lengthy hospitalizations
- Characterized by extreme emotional sensitivity/high reactivity, intense emotional responses, slow return to baseline
- Based upon the Bio-Social Theory of the interaction between biology and environment

Biosocial Theory of BPD

Emotional Sensitivity:

- High sensitivity and immediate reaction
- High arousal and intense physical response
- Slow return to baseline

Invalidating Environment:

- Lack of appropriate response from family, i.e. "poor fit"
- Chaotic family or living environment (sexual, physical, verbal, and emotional abuse; unsafe living environment due to crime, poverty, mental illness, substance abuse, death, or war)

Pervasive emotional dysregulation:

- Unclear sense of identity and confusion
- Inability to recognize and regulate emotions within the window of tolerance
- High risk of PTSD, addictions, self-injury, suicide, and mood, personality, and dissociative disorders

Dialectical Behavior Therapy (DBT)

- Derived from Cognitive Behavior Therapy but emphasizes: Validation, Dialectics, and Mindfulness

- Balances the dialectical concept of Acceptance and Change: you are doing the best you can, and you need to work harder to change

- Four Skills Modules: Mindfulness, Distress Tolerance, Emotion Regulation, and Interpersonal Effectiveness

- Now adapted to use with other disorders, including substance abuse, eating disorders, mood disorders (bi-polar disorder, anxiety, and depression), PTSD, anger management

DBT Skills Modules: Creating a Life Worth Living

Behaviors to Increase

1. Mindfulness Skills (Stronger sense of self, better attention span, control over thinking)

2. Interpersonal Effectiveness (Stronger relationships, better skills at negotiating relationships to get your needs met)

Behaviors to Decrease

1. Emptiness, scattered thoughts, obsessive thoughts, confusion about self.

2. Fear of abandonment or rejection by others, conflicted "hot and cold feelings about people.

DBT Skills Modules: Creating a Life Worth Living

Behaviors to Increase	Behaviors to Decrease
3. Emotion Regulation (More "even" moods, acceptance of feelings, control over feelings)	3. Up and down mood swings, mood driven choices and behavior
4. Distress Tolerance (Healthy choices when under stress, even in crisis, increased ability to handle pain and stress for longer periods of time)	4. Desperate, impulsive behaviors that lead away from a happy future.

DBT Stages of Treatment

- **Orientation and Commitment to Therapy and Life**

- **DBT Stage 1:** Attaining basic capacities, stabilization, and connection through the four components of the standard outpatient treatment model:

  - Individual Therapy
  - Skills group
  - Phone coaching
  - Consultation Team (includes uncontrolled ancillary treatments)
    - Pharmacological Therapy
    - Acute Inpatient Psychiatric Treatment

DBT Stages of Treatment, cont'd

- **Stage 2:** Processing the past and reducing Posttraumatic Stress through various trauma therapies, including EMDR and Exposure Therapy (Foa), through recognizing and feeling emotions without being overwhelmed by them, and coming to a new understanding of and meaning for the trauma

- **Stage 3:** Synthesis leading to solving ordinary life problems and living an ordinary life: food, clothing, shelter, basic necessities, satisfactory relationships

- **Stage 4:** Self-actualization and a more fulfilling life: joy, spirituality, culture, arts, lasting legacy or contributions to family and society

DBT Standard Outpatient Treatment

- Individual psychotherapy (1 hour weekly) based upon the client's self report on their diary card

- DBT Skills Training Group (2-2.5 hours weekly) for 24 weeks, which may be repeated for a total of 48 weeks

- Telephone Coaching (PRN, within the therapists or program's limits).

- DBT Consultation Team Meeting for a minimum of 1 hour weekly for skills instructors, individual therapists, and other treatment providers

DBT: Three Hierarchies of Behavioral Treatment Targets

- Life threatening
- Therapy interfering
- Quality of life interfering

LIVING EFFECTIVELY: Skills for Improving Life

Target Behaviors/Emotions

Life Threatening

	Not a Problem 0	Slight 1	Moderate 2	Severe 3	
Suicidal Behaviors					
Suicidal Thoughts					
Parasuicidal Behaviors (harm self/no intent to die)					
Starving					

Treatment Interfering

	Not a Problem 0	Slight 1	Moderate 2	Severe 3
Breaking Commitments				
Not Asking for Or Accepting Help				
Not Doing Homework/ Procrastination				
Not Taking Medication				
Quitting Therapy/ Counseling or Group				

LIVING EFFECTIVELY: Skills for Improving Life

Target Behaviors/Emotions

Quality of Life Issues

	Not a Problem 0	Slight 1	Moderate 2	Severe 3		Not a Problem 0	Slight 1	Moderate 2	Severe 3
Alcohol					Stealing				
Anger Outburst					Video Games (overuse)				
Bingeing					Violence				
Breaking Commitments					Other				
Compulsive Exercise					**Problem Emotions**				
Drugs					Anger				
Gambling					Anxiety				
High Risk Behaviors					Contempt/Hatred				
Hurting Others					Depression				
Internet Addiction					Despair				
Lying					Fear				
Not Asking For Help					Guilt				
Not Doing work Procrastination					Hopelessness				
Obsessing/Dwelling					Jealousy				
Overworking					Sadness				
Perfectionism					Shame				
Pornography					Guilt				
Purging					Other:				
Self Isolation/ Withdrawal									
Sexual Promiscuity									
Skipping class/work									
Smoking									
Spending/Shopping									

DBT Diary Card

NAME: _____ DATE: _____

Targets													Emotions						
Date	Self Harm		Suicidal Ideation	Misery/ Pain									SelfEsteem Acceptance	Compassion Love	Anger/ Frustration	Joy/ Contentme	Shame/ Guilt	Sadness/ Depressi	Fear/ Anxiety
	Urge	Action	0-5	0-5	Urge	Action	Urge	Action	Urge	Action	Urge	Action	0-5	0-5	0-5	0-5	0-5	0-5	0-5

SUICIDAL IDEATION: 0 = No thoughts 1 = Fleeting thoughts 2 = More intense 3 = Very Intense 4 = Developing specific plan 5 = Acting on plan

INTENSITY: 0 = Not at all 1 = A bit 2 = Somewhat 3 = Rather Strong 4 = VERY Strong 5 = EXTREMELY STRONG

How often did you fill in your diary card? _____ DAILY _____ 2 / 3 X'S WK _____ 1X WK Urge to quit therapy? _____

Notes for the Week:

	Agenda Items:
Mon	
Tue	
Wed	
Thurs	
Fri	
Sat	
Sun	

Times needed to use telephone consultation? _____ Times did use telephone consultation? _____

DBT Skills Used

Fill in the number for the degree to which you used the skill.

1. Realized afterwards that I should have used skill.
2. Thought about skill but chose not to use it.
3. Realized afterwards that I did use skill effectively.
4. Mindfully tried to use skill but wasn't effective.
5. Mindfully used skill effectively.

	M	T	W	T	F	S	S	
Core Mindfulness								**Wise Mind:** Accessed wisdom. Know truth. Be centered and calm. Balanced Emotional Mind and Reasonable Mind. Meditate.
								Observe: Just notice the experience. "Teflon mind." Control your attention. Smell the roses. Experience what is happening.
								Describe: Put experiences into words. Describe to yourself what is happening. Put words on the experience.
								Participate: Enter into the experience. Act intuitively from wise mind. Practice changing the harmful and accepting yourself.
								Nonjudgmental stance: See but don't evaluate. Unglue your opinions. Accept each moment.
								One-mindfully: Be in-the-moment. Do one thing at a time. Let go of distractions. Concentrate your mind on the task at hand.
								Effectiveness: Focus on what works. Learn the rules. Play by the rules. Act skillfully. Let go of vengeance and useless anger.
Interpersonal Effectiveness.								**Objective effectiveness:** *DEAR MAN: Describe. Express. Assert. Reinforce. Mindful. Appear confident. Negotiate.*
								Relationship effectiveness: *GIVE: Gentle. Interested. Validation. Easy manner.*
								Self-respect effectiveness: *FAST: Fair. No Apologies. Stick to values. Be Truthful. Cheerleading.*
								Prioritizing: Ranking the importance of your objective, the relationship, and self-respect.
								Challenging myths and beliefs: Dispute the thoughts and beliefs that reduce interpersonal effectiveness.
								Options for intensity: Determining how strongly to ask for or say no to something.
Emotion Regulation								**Identifying primary emotions:** Use the model of emotions to identify your primary emotions.
								Checking the facts: Identify the facts of the situation (rather than thoughts, interpretations, or beliefs). Don't act upon assumptions. Be explicit, look for proof.
								Problem solving: Identify the problem, check the facts, identify your goal, brainstorm solutions, evaluate solutions, put a solution into action, and evaluate the results.
								Opposite-to-emotion action: Change emotions by acting opposite to the current emotion (when it isn't justified). Approach rather than avoid.
								Acquire positives in the short-term: Doing pleasurable things that you can do now that don't interfere with long-term goals.
								Acquire positives in the long-term: Making choices that match morals and values, do things that lead to accomplish your quality of life goals.
								Build mastery: Try to do one (hard or challenging) thing a day to make yourself feel competent and in control.
								Cope ahead: Imagine how you would skillfully cope with a situation before you are in it; rehearse it imaginably & behaviorally. Problem solve, develop contingency plans.
								PLEASE: Reduce vulnerability, treat: *Physical illness*, balance *Eating. Avoid* drugs, balance *Sleep. Exercise* daily.
								Letting go of emotional suffering: Attend to emotional experiences in the present, don't ruminate on the past or worry about the future.
								Managing extreme emotions: Crisis survival skills, mindfulness of current emotions, apply emotion regulation skills, resist urges to act in emotional mind.
								Troubleshooting emotion regulation: Steps to follow when changing your emotion doesn't work.
Distress Tolerance								***TIPP:*** *Temperature. Intense exercise. Progressive muscle relaxation. Paced breathing.*
								Distract: Wise Mind *ACCEPTS Activities. Contributing. Comparisons. Emotions. Pushing away. Thoughts. Sensations.*
								Self-soothe with the 5 senses. Enjoy sights, sounds, smells, tastes and touch. Be mindful of soothing sensations.
								IMPROVE the moment: *Imagery. Meaning. Prayer. Relaxation. One* thing in the moment. *Vacation. Encouragement.*
								Pros and cons: think about the +/- aspects of tolerating distress and the +/- aspects of not tolerating distress (engaging in impulsive behavior)
								Observing your breath: Breathing to center yourself. Count your breaths, inhale slowly, exhale more slowly, use your diaphragm, use cues like "Be Calm", "Re-Lax"
								Half-smile: If you can't change your feelings, change your face. Create posture of acceptance, willingness, and openness to experience.
								Awareness exercises: Focus attention on allowing yourself to tolerate distress. Use positive affirmations like "You can cope," "You can get through this".
								Radical acceptance: Choose to recognize and accept reality. Freedom from suffering = acceptance of facts from deep within / **not** approval.
								Turning the mind: Choosing over and over again to accept even though emotion mind wants to reject reality.
								Willingness: Doing what is needed in each situation. Use open up-turned hands.
Other								**Validate yourself and/or someone else**
								Recognized need for skill but didn't know which one. (Check which day of the week)

DBT focuses on changing problematic behaviors

- **Diary Card used daily to track:**
  - Life threatening, therapy interfering, and quality of life issue behaviors based upon target hierarchy
  - Emotional intensity
  - Daily events
  - Use of skills

- **Behavior Change Analysis:** What are the factors/links that lead to my ineffective behaviors? (cause and effect; ABCEF= Actions, Body sensations, Cognitions/thoughts, Events, Feelings)

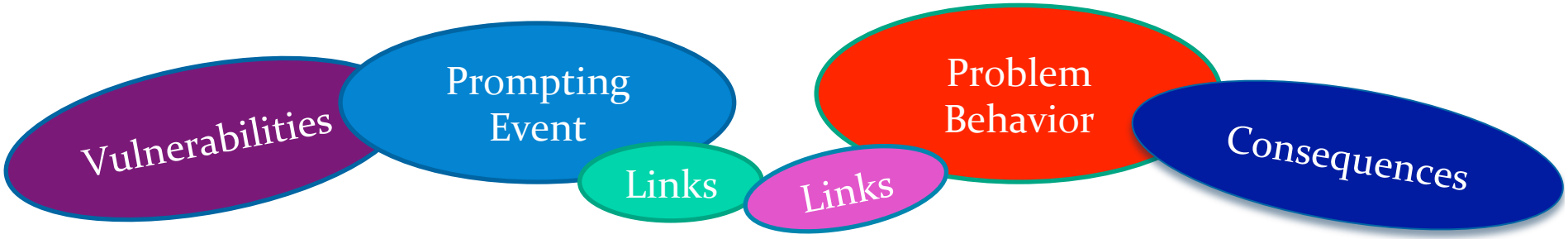
DBT focuses on changing problematic behaviors

- **Missing Link Analysis:** What is interfering with my failure to engage in my identified and desired behaviors? (problem solving)

- **Reinforcement Principles:** Positive and Negative Reinforcement: what is maintaining my problem behaviors, and what can I do to reinforce more effective behaviors

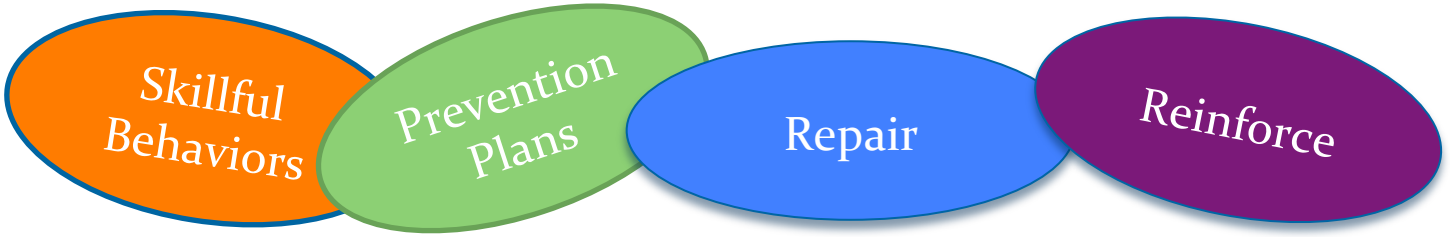
- Can help clients **prepare for TICES recording**

Behavior Chain Analysis



Step 1: Describe the PROBLEM BEHAVIOR.
Step 2: Describe the PROMPTING EVENT that started the chain of events leading to the problem behavior.
Step 3: Describe the factors happening before the event that made you VULNERABLE to starting down the chain of events toward the problem behavior.
Step 4: Describe in excruciating detail the CHAIN OF EVENTS that led to the problem behavior.
Step 5: Describe the CONSEQUENCES of the problem behavior.

Behavior Chain Analysis



To change behavior:

Step 6: Describe **SKILLFUL** behaviors to replace problem links in the chain of events.

Step 7: Develop **PREVENTION PLANS** to reduce vulnerability to stressful events.

Step 8: REPAIR important or significant consequences of the problem behavior.

Step 9: REINFORCE positive behavior changes

Missing Link Analysis

Used to understand why an effective behavior did not occur:

1. Did I know what effective behavior was needed or expected? ___Yes ___No If No, what got in the way of knowing?_____ Problem solve:_____
2. If yes to Question 1, was I willing to do what was expected or needed?___Yes ___No If No, what got in the way of doing what was needed?_____ Problem solve:_____
3. If yes to Question 2, did the thought of doing what was needed or expected ever enter my mind? ___Yes ___No If no, problem solve_____
4. If yes to Question 3, what got in the way of doing what was needed or expected right away? If Yes to Question 3, what got in the way of doing what was needed or expected right away? Problem solve_____ STOP

Why use DBT skills training to complement EMDR?

- For individuals who experience high levels of emotional activation, DBT skills address tolerance/survival of emotional crisis, everyday regulation of emotional experience, and proactive reduction of emotional vulnerability.
- Trauma work requires the capacity to allow experiences and emotions that are difficult to tolerate into awareness in order for change to occur. DBT skills enable clients to identify and experience emotions while staying within or returning to their optimal level of arousal.
- The consistent use of numerical ratings on DBT diary cards to assess emotions and experiences familiarize EMDR clients with a means of describing experience that is part of the Standard Protocol, e.g. SUDS, VOC.

Why use DBT skills training to complement EMDR? cont'd.

- Although many EMDR clients will have good baseline interpersonal skills, these may quickly deteriorate in response to trauma triggers. Other clients will not have strong skills in this area due to a history of interpersonal trauma and neglect. DBT teaches missing skills, and strengthens weak ones.

- DBT skills training enables clients to begin remediating skills that were never developed due to chaotic environments in their early life experiences. They can help clients progress beyond early developmental levels in which their emotional maturation has been delayed or stuck in early life stages.

Why use DBT skills training to complement EMDR? cont'd.

- Carole Lovell (Shapiro, 2005, p. 281),"Since I have been using EMDR and other trauma techniques in my [DBT] groups, the hospitalization rate of group members has gone from three or four within every group period to one for the past 2 years. With a combination of individual and group sessions, focusing on skills, awareness, and trauma, I have developed a unique and effective approach to therapy with trauma and abuse survivors."

DBT Stage 2. Trauma Processing

- After stabilization, increased affect tolerance, and resource development is completed, processing with the standard protocol of EMDR traumatic memories can begin.

- Both DBT and EMDR can incorporate Safe or Calm Place and other Imaginal activities, such as positive memories and the conveyor belt

- While RDI (Resource Development Installation) is primarily associated with EMDR, this can also be part of DBT skills training and individual therapy, such as focusing on previous successes, coping ahead, and mastery.

DBT Stage 2: Trauma Processing

Starts When:

- Rapport and trust is established
- Crises are stabilized
- Chaos is reduced
- Symptom reduction has occurred (anxiety/ depression/addictions)
- Client feels ready and gives permission to process

EMDR=Eye Movement Desensitization and Reprocessing Therapy

- Founded by Francine Shapiro in 1987

- Researched evidenced based treatment, proven effective for trauma treatment and other diagnosis

- AIP: Adaptive Information Processing=the natural brain structures are stimulated through BLS (Bilateral Stimulation) to complete processing of traumatic memories

EMDR=Eye Movement Desensitization and Reprocessing Therapy

AIP Model:

- Traumatic experiences are encoded in state-specific dysfunctional form in separate memory networks

- Affect, perceptions, sensory experiences are frozen in time in their own neural network

- Memory, including affect, can be triggered by internal and external stimuli resulting in intense emotional and behavioral responses

EMDR: AIP Model and BPD

- The AIP Model "views negative behaviors and personality characteristics as the result of dysfunctionally held information" (Shapiro, 2001)

- The emotion dysregulation seen in clients with BPD can be viewed as a result of the triggering of traumatic memory through any of the five senses: visual, olfactory, auditory, tactile, taste, as well as thoughts and dreams.

- Individuals with BPD can also be viewed as having different "ego-states" or "parts" consistent with tendency to manifest extreme polarities in emotions, cognition, and behaviors. For more information refer to Internal Family System Therapy (Richard Schwartz) and Ego State Therapy (John Watson)

EMDR=Eye Movement Desensitization and Reprocessing Therapy

- Utilizes dual attention, that is, being grounded in the present while processing past memories and events, and imagining future events

- Can address implicit, explicit, and somatic memories

- Standardized protocol as well as special protocols for addictions, bi-polar, grief, performance, etc.

-

EMDR=Eye Movement Desensitization and Reprocessing Therapy

Expanded for treatment of disorders besides PTSD:

- addictions
- complicated grief, postpartum depression
- recent traumatic events
- bi-polar disorder
- dissociative disorders
- chronic pain
- attachment disorders
- performance enhancement
- phobias, obsessive compulsive disorder, hoarding disorder
- body dysmorphic disorder, eating disorders

Phase I. Stabilization, Case Conceptualization, History Taking

- Build rapport
- Crisis management: Financial, Legal, etc.
- Assess the need for psychotropics
- Assess coping styles
- Trauma history and strengths unfold as trust builds
- Family Genogram
- ACES (Adverse Childhood Experiences Study)

Phase I. Stabilization, Case Conceptualization, History Taking, cont'd.

- Assess for addictive disorders (AUDIT, NIDA)
- Assess for dissociative disorders (DES)
- Assess for core beliefs/schemas (YSQ-2=Young Schema Assessment)
- Client's strengths, goals, developmental deficits
- Affect tolerance: hyper or hypo arousal?
- Supportive systems: family, medical, organizations (religious), friends

Phase II. Extended Preparation and Symptom Reduction

- Explain EMDR
- Rapport building, develop a collaborative approach to healing trauma wounds
- Grounding exercises for hypo arousal
- Safe place, relaxation for hyper arousal
- Psycho-education, increase affect tolerance

Phase II. Extended Preparation and Symptom Reduction, Cont.'d

- Ego Strengthening exercises, Resource Development Installation (RDI), Imaginal Nurturing (April Steele), re-parenting
- Ego state work and coping skills to build resources for childhood deficits and create safety
- Collaboration and permission. Proactive support and engagement

Phase III. Assessment

- Trauma Timeline
- 10 Best and Worst Memories with client's age and SUDs (Systematic Units of Distress) levels
- Target first with a small "t" around a secondary trauma to "test" readiness for first processing.
- Images, flashbacks, nightmares
- Negative Cognition

Phase III. Assessment, Cont'd.

- Positive Cognition
- VOC (Validity of Positive Cognition, 1-7)
- Emotions
- SUDs (Systematic Units of Distress, 1-10) for target event
- Body sensations
- Sometimes installing future template first will identify resources the client needs to face the trauma.

Phase IV. Desensitization

- Remind client of their resources and install (RDI)
- Process target memories, negative beliefs, emotions, and somatic sensations with bi-lateral stimulation (BLS)
- Have cognitive interweaves ready when client gets struck around responsibility, safety, and choices.
- Address blocking beliefs and defenses

Phase IV. Desensitization

- Be prepared to separate loyalty from responsibility when the client assumes responsibility for the behavior of unresponsive, neglectful or abusive adults.

- When processing complex trauma it is important to create more structure for the client so they do not become overwhelmed and shut down or relapse. Take one small step at a time (Resource Sandwich; Jim Knipe's Back of the Head assessment).

- Expect SUDs score may not get to zero in one or two sessions. SUDS may actually go up during processing as more traumatic and somatic memories are accessed.

Phase IV. Desensitization

- Contain at the end of the session and ground to present (grounding, container)
- Remind client of their resources and take them back to place of relaxation (Safe Place, Body Scan, Deep Breathing, Progressive Muscle Relaxation)
- Assess original target and SUDS at next session, and continue to process until SUDS reaches 0-1
- Use somatic processing when the client is not aware of emotions
- Create “trauma sandwich” with resourcing at the beginning and end of session

Phase V. Installation

- Start installation process after the SUDs is 0 or 1.
- When the positive cognition does not go to a VOC of 7, expect to do some processing around the blocking beliefs that keep it from being a 7.

Phase VI. Body Scan

- Body Scan- May trigger more trauma, contain memory if this happens. Clean scan indicates the target is cleared.

Phase VII. Closure

- Closure- Remind clients that processing will continue after the session, and ask them to keep TICES Log (Trigger, Images, Cognitions, Emotions, Sensations). These can be future processing targets.

- Containment, safe place, and grounding at the end of the session will reduce client's reactivity.

Phase VIII. Reevaluation

- Continue with previous target memory unless some new information that the client recalls between sessions identifies some blocking beliefs that need processing to reduce the SUDS score or increase the VOC score.

Complications Processing with EMDR Developmental Deficits

- Pervasive pattern where the sense of self is experienced as inadequate/defective/bad
- Lack of integration of mood and self awareness, cut off from feelings and body awareness, numbing as a coping skill
- Difficulty with self regulation/self control
- Difficulty in relationships, constant crisis
- Complications with compulsive behaviors, substance abuse, eating disorders
- Living as if the past is the present
- Confusion between self and others regarding responsibility
- Poor boundaries with abusers

Similarities Between DBT and EMDR

Both:

- Are evidence based approaches
- Have strong, dynamic founders
- Treat clients with trauma histories
- Address the problem of the past intruding upon the present
- Teach new skills
- Increase client capabilities

Similarities Between DBT and EMDR

Both:

- Have a theoretical model that guides treatment: DBT=Biosocial Theory, EMDR=AIP
- Have a model of treatment that has stages (DBT-4 Stage) or phases (EMDR-8 phase protocol)
- Both have specific materials (DBT) or protocols (EMDR) for diverse client populations and diagnoses (children, adults, adolescents, etc.)
- Address affective dysregulation, cognitive dysregulation, behavioral dysregulation, and interpersonal and self dysregulation

Differences Between DBT & EMDR

- DBT views affect dysregulation as the driving force behind BPD, as it results in a cascade of behavioral, cognitive, interpersonal, and self-dysregulation coping adaptations

- EMDR views behavioral, cognitive, interpersonal and self-dysregulation characteristics as the results of incomplete memory processing in the hippocampus, or a failure to convert sensory experiences in an adaptive way

Differences Between DBT & EMDR

- During reprocessing, EMDR typically "follows the client" and gives equal priority to level of disturbance (emotional, somatic) and validity of cognition (cognition or beliefs)

- DBT is typically offered through a team approach with both group psycho education and individual therapy sessions

- EMDR is delivered in a one-on-one relationship with the therapist in individual therapy

What does DBT offer EMDR?

A range of DBT skills to stabilize client for trauma work:

- Core mindfulness
- Distress Tolerance
- Emotion Regulation
- Interpersonal Effectiveness

A set of DBT skills adapted for adolescents, couples, and families that enables you to utilize and personalize skills for varied client populations

What does DBT offer EMDR?

A methodology for teaching skills:

- Lecture/Description
- Workbooks, Books, and Handouts
- Diary Cards
- Role play
- Videos, YouTube
- Metaphors (making lemonade out of lemons)
- Group and Individual Practice
- Group and Individual Feedback

What does DBT offer EMDR?

- Strategies for addressing dysfunctional behaviors
  - Parasuicidal/self-injurious behaviors
  - Therapy interfering behaviors
  - Quality of life interfering behaviors

- A stage of treatment model which has criteria for readiness for trauma reprocessing or exposure therapy

What does DBT offer EMDR?

Flexibility in offering any evidence based approach to addressing PTSD symptoms in Stage 2

- EMDR (Shapiro)
- EMDR=Imaginal Exposure, DBT=Prolonged Exposure Therapy (Edna Foa)
- Any evidence-based trauma focused treatment

What does DBT offer EMDR?

- A bio-social theory explaining the etiology of Borderline Personality Disorder as a result of the interaction (or mismatch) between a temperament (difficult to soothe) and an invalidating environment characterized by:
  - Physical abuse=72 %
  - Sexual abuse= 26 to 50%
  - Having one's experience pervasively dismissed, ridiculed, discounted, or contradicted

What does EMDR offer DBT?

- The AIP model: Adaptive Information Processing
- A variety of resources:
  - Light stream
  - Calm, safe place
  - Container
- Briefer treatment
- A more efficient but just as effective way of processing trauma (compared to PLE)

What does EMDR offer DBT?

Compared to Prolonged Exposure Therapy:

- EMDR is as effective
- Is more user friendly (fewer dropouts)
- Can target multiple trauma incidents that share a common negative cognition simultaneously
- Is more effective in treating multiple traumatic incidents than exposure
- Does not require clients to practice in vivo exposure experiences outside of therapy

What does an integrated DBT and EMDR model look like?

Four Stage Model:

- **DBT Stage 1:**
  - Reduces parasuicidal behavior
  - Reduces therapy-interfering behavior
  - Reduces quality of living behavior problems
  - Builds resources (DBT and EMDR skills)
  - Stabilization (EMDR)

What does an integrated DBT and EMDR model look like?

Four Stage Model:

- **DBT Stage 1:**
  - Offers the advantages of tracking and measuring behaviors and results (Diary Cards) that apply to EMDR processing (SUDS=Systematic Units of Distress, VOC= Validity of Cognition)
  - Offers a combination of individual and group therapy to enable generalization of skills

What does an integrated DBT and EMDR model look like?

Four Stage Model:

- **DBT Stage 2**
  - Trauma work using EMDR 8 Phase Protocol
  - Therapist can titrate back to skills reinforcement in both individual and DBT skills group therapy as needed

What does an integrated DBT and EMDR model look like?

Four Stage Model:

- **DBT Stage 3:** Synthesis leading to solving ordinary life problems and living an ordinary life: food, clothing, shelter, basic necessities, satisfactory relationships
  - EMDR processing for performance, strengthening ego resources
  - EMDR Future Template

What does an integrated DBT and EMDR model look like?

Four Stage Model:

- **DBT Stage 4:** Self-actualization and a more fulfilling life: joy, spirituality, culture, arts, lasting legacy or contributions to family and society
  - EMDR processing for performance, strengthening ego resources
  - EMDR Future Template

Group work in an integrated DBT and EMDR model

General Information:

- Bio-social theory
- Theory of Trauma and Optimal Arousal Zones
- DBT Assumptions
- Diary Cards instruction
- Skills Module Instruction
- Homework Review
- Role plays
- Lecture and Discussion

Individual work in an integrated DBT and EMDR model

- Orientation and commitment
- Screening for dissociation (DES)
- Young Schema Assessment for Core Beliefs (YSQ-2)
- Informed consent
- Target Behaviors indentified and incorporated on client's Diary Card
- Diary Card review
- Behavior Chain Analysis
- Missing Link Analysis
- Practice (role plays) for generalization and reinforcement according to client's specific needs

Group work in an integrated DBT and EMDR model

Mindfulness:

- Meditation and Deep Breathing
- Safe Place (can also use with bilateral music)
  - Provide alternate activities for clients who have a propensity to dissociate during imaginal activities (coloring, grounding, etc.)
- Use the 5 senses to increase awareness of all sensations and memories
- Body Awareness/Somatic Experiencing: Observe, Describe, Non-judgmentally; One-Mindfully=Body Scan
- States of Mind: Wise Mind, Reasonable Mind, Emotion Mind=Two Handed Interweave/Synthesis
- Middle Path/Synthesis of Dialectics: Two handed interweave, "Kernel of Truth"

Group work in an integrated DBT and EMDR model

Mindfulness:

- Imagery/RDI=Positive Feeling State/Memories; Light Scan; Performance Enhancement
- Tapping in/Butterfly hug: for positive feeling state, positive attributes and strengths, stepping out of the circle (Shapiro, R., 2009 p. 273)
- Moving back and forth from a positive to a negative memory and back to a positive memory: Titrating, Back of the Hand (Knipe, 2015)
- Resource Figures: Tap in Nurturers, Sources of Wisdom, Courage, Strength, etc. (Parnell, 2007)
- Grounding/Containing: manages abreactions and flashbacks

Group work in an integrated DBT and EMDR model

Distress Tolerance:

- Ending sessions & dealing with abreactions
  - Self-soothing
  - TIPP Skills (Temperature, Intense Exercise, Paced Breathing, Paired Muscle Relaxation/Progressive muscle relaxation)
  - Body Scan Meditation
  - Sensory Awareness Step-by-Step
- Self-care between sessions: Improve the Moment, ACCEPTS

Group work in an integrated DBT and EMDR model

Distress Tolerance:

- Radical Acceptance: accepting the past frees the client to effectively deal with the present and future
- Turning the mind: Turning the mind from what you wish was, to what is; choosing to accept repeatedly
- Willingness: to do what is needed, to face difficult memories and emotions
- Being Mindful of Current Thoughts: BLS, allowing whatever comes up to come up in a stream of consciousness
- Not blocking or suppressing thoughts

Group work in an integrated DBT and EMDR model

Emotion Regulation:

- Maintaining optimal arousal between hypo and hyper arousal
- Mindfulness of current emotions
- Understanding and naming emotions
- Willingness to experience rather than numb emotions
- Myths about emotions
- Model for describing emotions
- Identifying emotional triggers, both internal and external: TICES
- Imagery: Nightmare Protocol

Group work in an integrated DBT and EMDR model

Emotion Regulation:

- Checking the facts
- Deciding when to use opposite to emotion
- Build mastery=RDI of positive success and attributes
- Accumulating Positive Emotions/Build Positive Experiences
- Cope ahead=Future Template; performance anxiety, hoarding
- Imagery: Nightmare Protocol

Group work in an integrated DBT and EMDR model

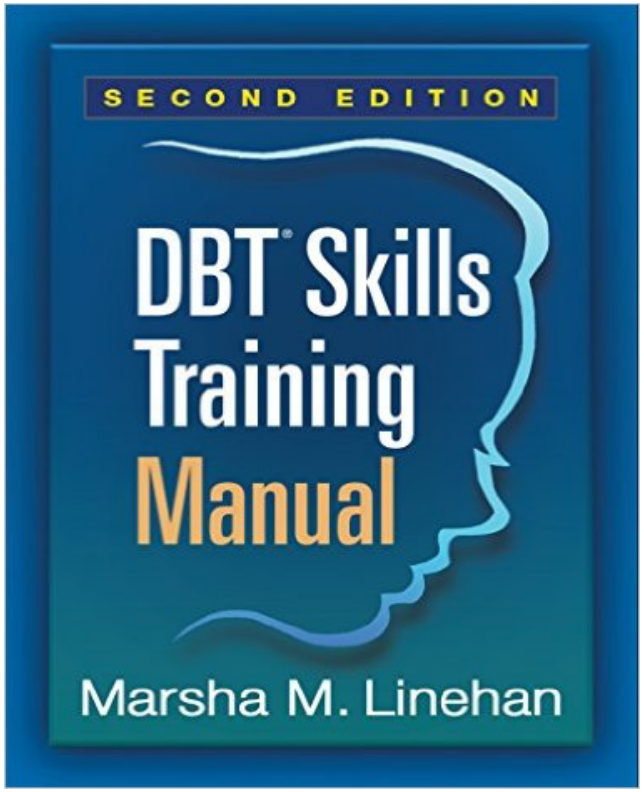
Interpersonal Effectiveness:

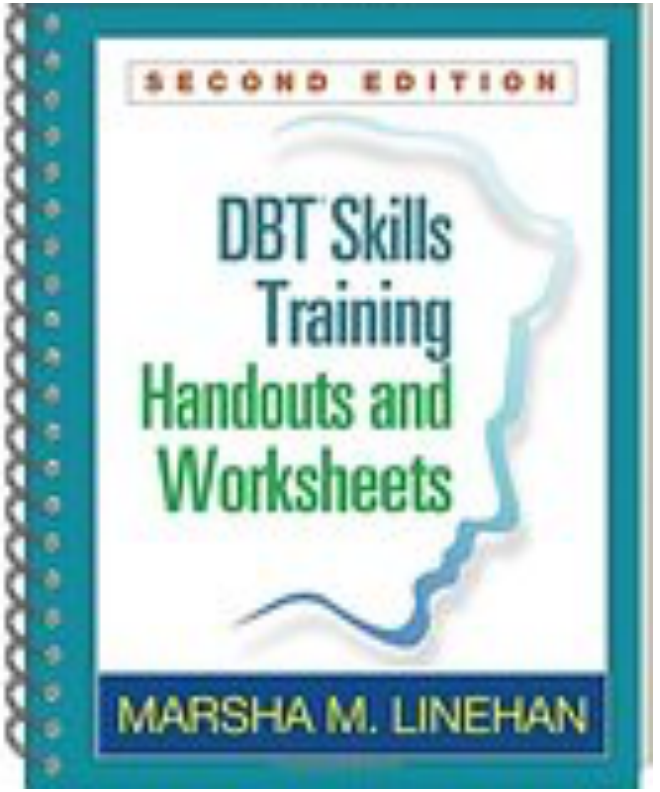
- Building relationships and ending destructive ones
- Setting boundaries
- Validation/Self-validation: I can learn to see myself differently; I don't have to accept others' interpretations of me or of events
- Challenging Myths about relationships
- Values and priorities

Challenging Myths/Positive Core Beliefs

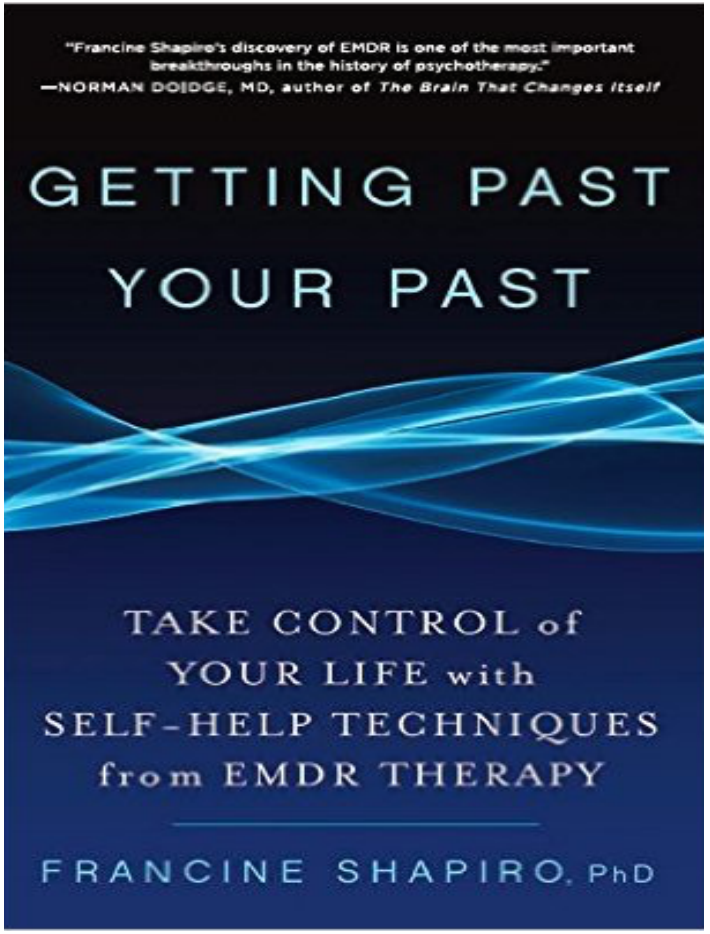
- It's safe to love and trust.
- It's safe to have feelings.
- It's safe to be vulnerable.
- I can ask for help and comfort.
- I can say no to unwanted requests.
- I can decide what I want in life.
- I did the best I could.
- I am fine the way I am.
- I can improve and succeed at my goals.
- I can make mistakes/I don't need to be perfect.
- I am lovable and worthy.

DBT Basic Resources





EMDR Basic Resources



Conclusions

- DBT and EMDR are two evidence based therapies that can be well integrated to effectively treat clients suffering from abuse and trauma, including both PTSD and Developmental or Complex Trauma
- Both have organizations (EMDRIA and Behavior Tech) that can enable therapists to obtain the necessary training and certification for therapist learn how to diverse clients with a variety of mental health diagnoses and disorders.
- dbtmo.org: free professional training, resources, team registration, directory
- Local EMDRIA and TRN groups (stlemdria.webs.com) for information, networking, training, referrals, consultation
- Questions and Comments