

Transdiagnostic Applications of DBT for Adolescents and Adults

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Dialectical behavior therapy (DBT) is an empirically supported treatment that was originally developed for chronically suicidal adults. Since the publication of the original treatment manual, DBT has been reconceptualized as a treatment that is broadly applicable for individuals who have difficulties regulating emotion. As such, the treatment can be applied transdiagnostically. Based on the flexibility and adaptability of the treatment, several adaptations have been made to the original protocol. Considerable empirical evidence now supports the use of DBT adapted for eating disorders, substance use disorders, and posttraumatic stress disorder. Moreover, developmentally appropriate adaptations have made the treatment applicable to youth samples. The current paper is geared toward practitioners and describes the various ways in which DBT has been modified for use with various populations and age ranges.

KEYWORDS: emotion dysregulation; DBT, suicidality; nonsuicidal self-injury

INTRODUCTION

Dialectical Behavior Therapy ([DBT]; Linehan, 1993) is an evidence-based treatment that was originally developed for chronically suicidal adults. DBT is often associated with the treatment of borderline personality disorder (BPD), which is characterized by emotional, behavioral, cognitive, intrapersonal, and interpersonal dysregulation (Linehan, 1993a). Individuals with pervasive emotion regulation difficulties often engage in ineffective, harmful behaviors, including chronic suicidal ideation, non-suicidal self-injury (NSSI; e.g., cutting, burning), disordered eating, and substance use, as a way to modulate affect (Klonsky, 2009). As such, the

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treatment is designed to mitigate this pervasive dysregulation by teaching skills to disrupt and replace these harmful compensatory behaviors with more effective coping strategies.

Although DBT historically has been linked with BPD, two factors have led to the broader application of DBT to other clinical populations. First, individuals with BPD tend to meet criteria for at least one additional diagnosis; on average, a person diagnosed with BPD meets criteria for approximately four additional disorders (Hamed et al., 2008). Thus, the treatment was designed to target myriad presenting problems across a range of diagnoses. Moreover, the empirical evidence for DBT demonstrates that the treatment is effective not only for reducing the major treatment targets of suicide and NSSI, but also associated psychological difficulties, such as depression and trauma symptoms (Lieb, Zanarini, Schmahl, Linehan, & Bohus, 2004). Accordingly, in recent years DBT has become more strongly associated with pervasive emotion dysregulation, rather than with BPD specifically. Because other psychological difficulties can similarly be characterized as reflecting an inability to modulate painful negative affect without engaging in dysfunctional coping strategies, the treatment was thus expanded and modified to accommodate other presenting problems, such as eating disorders, substance use disorders, and trauma.

Dialectical behavior therapy offers a multi-modal, comprehensive, and flexible treatment approach that can be used transdiagnostically with both adults and adolescents who have a range of emotion regulation difficulties. Standard DBT is a principle-based treatment that includes weekly individual therapy, as-needed between-session coaching, weekly group-based skills training, and weekly consultation team meetings for therapists (for a description of modes, targets, and stages of treatment, see Linehan, this issue). The essence of DBT lies in the therapist's skillful blending of acceptance- and change-based strategies (Linehan, 1993). Acceptance-based strategies in DBT are based on the principles of Zen, wherein clients learn to observe and describe their behaviors, thoughts, emotions, and environments without judgment and without trying to change themselves or their situations. Change-based strategies in DBT are based on the principles of behaviorism and include interventions such as exposure, contingency management, problem solving, and cognitive restructuring. DBT therapists are able to weave acceptance- and change-based strategies together based on a well-formulated case conceptualization and target hierarchy, which combine to dictate the moment-by-moment focal point in therapy sessions. This blend of strategies is critical for individuals with

severe emotion dysregulation because it is likely they will experience change without acceptance as invalidating of their difficulties, whereas acceptance without change is insufficient to moving them toward their goals.

DBT AS A TRANSDIAGNOSTIC TREATMENT APPROACH

The recent psychological literature has focused strongly on the construct of emotion dysregulation as the common element across most psychological disorders. Several treatments that have emerged in recent years have focused explicitly on transdiagnostic therapeutic applications, with emotion regulation as a primary treatment focus (e.g., the Unified Protocol; Barlow et al., 2010). Because DBT targets problematic emotions and behaviors that occur across a range of psychological disorders, it is broadly applicable as a transdiagnostic treatment strategy (see Ritschel, Miller, & Taylor, 2013). For example, in adolescents, suicide and nonsuicidal self-injury (NSSI) are commonly observed not only in the context of BPD, but also in bipolar disorder (Goldstein et al., 2007), depression and anxiety disorders (Lewinsohn, Rohde, & Seeley 1996), PTSD (Giaconia, Reinherz, Silverman, Pakiz, Frost, & Cohen, 1995), and conduct disorder (Lewinsohn et al., 1995). Based on its emphasis on case conceptualization and behavioral targeting, DBT can be applied across these various diagnostic categories to address suicide and NSSI as well as the symptoms that present within each diagnostic class. The flexibility and adaptability of the treatment are accounted for by two factors: (1) DBT's emphasis on balancing change and acceptance strategies, and (2) the focus on emotion dysregulation as the common element in psychological distress and ineffective regulatory strategies, as opposed to a singular focus on specific diagnoses or symptoms.

Since its development, DBT has been adapted for use with clients across a variety of age ranges, diagnostic categories, and treatment settings (Ritschel, Miller, & Taylor, 2013). In adult samples, the empirical literature supports the use of DBT as a treatment for BPD comorbid with substance abuse (Linehan et al., 1999) and PTSD (Harned, Korslund, & Linehan, in press). Independent of a BPD diagnosis, empirical literature supports the use of DBT for individuals with treatment-resistant depression (Harley, Sprich, Safren, Jacobo, & Fava, 2008), eating disorders (Safer, Telch, & Agras, 2001; Telch, Agras, & Linehan, 2001), and depression in older adults with mixed personality features (Lynch et al., 2007).

Recently, DBT has been expanded for use with adolescents with a variety of psychological disorders, including those with borderline person-

ality features and who engage in suicidal behavior and/or NSSI (Mehlum et al., 2014; Miller, Rathus, & Linehan, 2007). Other research supports the use of DBT with adolescents diagnosed with the following Axis I disorders: eating disorders (Salbach-Andrae et al., 2009), bipolar disorder (Goldstein, Axelson, Birmaher, & Brent, 2007), and oppositional defiant disorder (Nelson-Gray et al., 2006). Additionally, DBT is a promising intervention for juvenile offenders (Trupin, Stewart, Beach, & Boesky, 2002).

Although a thorough review of each of these adaptations is beyond the scope of the current paper, in the pages that follow we review three of the DBT modifications that have the strongest empirical support (i.e., for substance use, eating disorders, and trauma). We also review one of the newest adaptations of DBT for individuals on the opposite end of the emotion dysregulation dialectic—individuals with emotional overcontrol and affective inhibition. We will focus our efforts here on the clinical adaptations that have been made for each of these modifications, although the empirical studies supporting these approaches are documented throughout.

DBT FOR SUBSTANCE USE DISORDERS (DBT-SUD)

Research has shown a high degree of comorbidity between substance use disorders (SUDs) and BPD. In fact, studies indicate that among individuals receiving treatment for BPD, between 21% and 67% also meet criteria for SUDs (Dulit, Fyer, Haas, Sullivan & Frances, 1990). Due to this overlap, as well as the tendency of individuals with comorbid BPD and SUDs to present with greater psychiatric difficulties than individuals with either disorder alone (Linehan et al., 1999), standard DBT has been adapted to address comorbid substance use problems. Several studies have shown support for the effectiveness of DBT-SUD for this population (Linehan et al., 1999, 2002).

Similar to the conceptualization of NSSI as a way to regulate intense negative emotions, substance use in DBT is viewed as a learned behavior whose function is to modulate painful emotions and negative mood states, such as sadness, boredom, shame, emptiness, rage, and misery. Because substance use is conceptualized as a form of behavioral dyscontrol, and not explicitly as a means of self-injury, it falls under quality of life interfering behavior in the treatment target hierarchy (unless, of course, drugs were taken as an intentional means to die by suicide, in which case it becomes the number one treatment target). Thus, the overall goals of DBT-SUD are to:

- (1) teach emotion regulation skills that reduce the need to engage in dysfunctional emotion regulation strategies,
- (2) reduce behaviors and obstacles that significantly interfere with quality of life and maintain drug-seeking behavior, and
- (3) promote more skillful behaviors that would allow individuals to function adaptively and create a life worth living.

Dialectical behavioral therapy for substance use disorders uses the same treatment modalities as standard DBT: clients are required to attend weekly individual therapy as well as skills-training group. Coaching calls and therapist participation in weekly consultation team meetings are also part of the treatment. The major departure from standard DBT lies in the significant emphasis DBT-SUD places on substance abuse and related behaviors. More specifically, DBT-SUD employs many of the strategies that have been shown to be successful in other substance abuse treatments; in fact, extant literature underscores many commonalities between DBT-SUD and more established substance abuse treatments (McMain, Sayrs, Dimeff, and Linehan, 2007). For instance, like relapse prevention ([RP]; Marlatt & Gordon, 1985), DBT-SUD uses problem-solving strategies (e.g., chain analyses; Rizvi & Ritschel, in press) to target high-risk interpersonal and contextual factors that are likely to precipitate relapse. Similar to motivational interviewing ([MI] Miller & Rollnick, 1991), DBT-SUD employs various strategies to enhance motivation to change (e.g., the use of devil's advocate as a commitment strategy) and utilizes validation strategies that center on empathy and acceptance. Dialectical behavioral therapy for substance use disorders also has some similarities to the 12-step approach (Alcoholics Anonymous, 1981); that is, both interventions emphasize abstinence as the ultimate treatment goal, use contingency management and reinforcement strategies to maintain abstinence, and recognize the importance of a community of individuals for recovery and support. Both also incorporate spiritual principles (Christianity in AA; Zen in DBT). Nevertheless, DBT-SUD differs from these approaches in that it is a comprehensive and integrated treatment with equal emphases on abstinence and harm reduction (compared to RP), requires significant time commitment (compared to MI), and views substance abuse as a learned behavior rather than a disease (compared to 12-step approaches).

DIALECTICAL ABSTINENCE

Just as the dialectical balance between acceptance and change is the foundation of standard DBT, DBT-SUD rests on the concept of dialectical abstinence. Dialectical abstinence has been defined as “a synthesis of

unrelenting insistence on total abstinence before any illicit drug abuse with an emphasis on radical acceptance, nonjudgmental problem-solving, and effective relapse prevention after any drug use followed by a quick return to the unrelenting insistence on abstinence” (Dimeff, Rizvi, Brown & Linehan, 2000, pg. 458). Because focusing on abstinence alone often leads to notable challenges (e.g., giving up, hopelessness) when clients relapse, dialectical abstinence balances the goal of absolute abstinence with a nonjudgmental problem-solving approach to setbacks. The negative emotions that clients typically experience after a relapse bring about conditions that make it more likely for individuals to continue to abuse substances, a phenomenon Marlatt and Gordon (1985) called the *abstinence violation effect* (AVE). Whereas insistence on absolute abstinence helps prolong the period between drug use episodes, relapse prevention helps to decrease the frequency and intensity of relapse following a period of abstinence (McMain, Sayrs, Dimeff & Linehan, 2007).

A common DBT strategy on the abstinence pole of the dialectic is to help individuals initially commit to shorter periods of abstinence. Thus, the goal is to keep clients drug-free by helping them link together shorter, time-limited drug-free periods, with increasingly longer durations of total abstinence and increasingly shorter durations of time spent in relapse. Therapists teach skills to help clients learn—and practice—cognitive self-control strategies that aim to convince one’s brain that drug use is not an option (Dimeff, Rizvi, Brown, & Linehan, 2000). The scope of abstinence (i.e., discontinuing all drug use vs. only the substances associated with the most significant impairment) depends upon the therapist’s case conceptualization (Dimeff & Linehan, 2008). For instance, if alcohol use typically precedes cocaine use, abstinence from alcohol may be necessary, even when the primary substance associated with impairment is cocaine.

On the relapse prevention pole of the dialectic, clients are reminded that lapses occur in part because new behaviors need to be learned and take time to become routine. The goal in this case is to help clients “fail well” by preparing them to sustain the least amount of damage and to get back on track quickly with the goal of total abstinence (McMain, Sayrs, Dimeff & Linehan, 2007). Clients are encouraged to use “just in case” thinking as a way to be planful about the possibility of relapsing in the future. Dimeff and Linehan (2008) used a football quarterback analogy to explain the process of dialectical abstinence: the goal is absolute abstinence, just as the ultimate goal in football is to get to the end zone to score a touchdown. Dialectical behavioral therapy for DBT-SUD therapists, like a quarterback, have to keep the team focused on the ultimate goal, only

stopping briefly to help the client get back up during relapse (downs) and quickly refocusing on the end goal—never dwelling on the slips along the way. “Failing well” involves acceptance that one has relapsed, awareness of the consequences of relapsing (including feelings of guilt and shame), and reparation of the possible harm done to self or others.

Commitment and Attachment Strategies

Clients are considered to be in the pre-treatment stage of DBT-SUD until they make a commitment to abstinence. Like butterflies that flutter in and out of treatment, clients with SUDs often have difficulty attending therapy regularly; thus, strategies were developed to increase clients’ attachment to the treatment and the therapist. These strategies include: orienting the client to possible attachment challenges at the beginning of treatment, increasing contact with clients through planned check-in phone calls between sessions, shortening or lengthening therapy sessions on an as-needed basis, and having sessions that include family members and friends to build connections with the client’s social network.

PATH TO CLEAR MIND

In standard DBT, three states of mind are taught: emotion mind, reasonable mind, and wise mind. In DBT-SUD, there are three analogues to these states of mind: addict mind, clean mind, and clear mind. Addict mind includes behaviors such as stealing or pawning goods to get money for drugs, actively seeking drugs, planning to use, maintaining contact with drug-using friends, and lying. Addict mind decisions are driven by impulses, urges, and drug cravings. Individuals in clean mind have made the decision to quit, and may even have successfully navigated a period of abstinence; however, they are also oblivious to the potential for relapse and are thus more vulnerable to future drug use. For example, they may continue to spend time with drug-using friends, keep too much cash on hand, or tell themselves that driving through their former dealer’s neighborhood is not a problem.

Similar to the standard DBT goal of achieving greater amounts of time in wise mind, the ultimate goal of DBT-SUD is attaining clear mind, in which clients no longer use substances and simultaneously prepare for the possibility of slipping back to abusing drugs (McMain, Sayrs, Dimeff, & Linehan, 2007). Several strategies are used to help clients achieve dialectical abstinence. First, therapists help clients track substance use with observe and describe skills. Therapists home in on decreasing the intensity and duration of cravings and urges to abuse illicit and prescription drugs

through distress tolerance skills. Clients also learn to avoid cues associated with drug abuse, including “burning bridges” to triggers associated with drug use, including people (e.g., severing ties to drug contacts), places (e.g., avoiding drug hang outs), or objects (e.g., discarding drug paraphernalia). Therapists help clients eliminate behaviors associated with drug use (e.g., selling drugs or socializing with drug users) and reduce cues that allow the client to retain drug use as an option (e.g., by getting a new phone number and discarding drug dealers’ contact information). Finally, therapists and clients work together on increasing clients’ healthy behaviors (e.g., pursuing social activities, making new friends) that support the overall goal of abstinence.

TREATMENT ADAPTATIONS

A few strategies were adapted to meet the needs of clients who abuse substances. Similar to standard DBT, DBT-SUD therapists prioritize life-threatening and therapy-interfering behaviors over drug use, which is generally considered a quality-of-life-interfering behavior. In some cases, however, drug use may be treated as a behavior that leads to imminent risk (e.g., drug overdose) or a therapy-interfering behavior (e.g., missing sessions due to substance use, coming to sessions under the influence). In these cases, substance use takes priority in individual therapy. Several strategies relevant to substance use were added to the existing DBT skills to address the challenges pertinent to individuals with SUDs (Dimeff & Linehan, 2008). This includes adding “alternate rebellion” (i.e., satisfying one’s wish to rebel without engaging in drug use) and “observing urges” skills to the mindfulness module; “building a life worth living” (by developing structure in life) skill to the emotion regulation module; “adaptive denial” (i.e., pushing away painful thoughts) and “burning bridges” skills to the distress tolerance module; and “eliminating cues” to use drugs as a self-management strategy. Finally, another modification in DBT-SUD involves splitting the usual 150-minute skills group into a 90-minute skills group and a 30-minute individual skills consultation. This change was adopted because empirical evidence (see Dimeff, Rizvi, Brown & Linehan, 2000) suggests that a number of clients with SUDs also have significant social anxiety, which prevents them from engaging fully in group sessions. For this reason, group leaders found it necessary to meet individually with group members to ensure that they are learning the skills.

DBT FOR EATING DISORDERS (DBT-ED)

Eating disorders (EDs), including anorexia nervosa (AN), bulimia nervosa (BN), binge eating disorder (BED), and eating disorder not otherwise specified (EDNOS), are often chronic conditions associated with high levels of impairment and psychological comorbidity. Studies suggest that 15% to 40% of clients with BN attempt suicide (Dulit, Fyer, Leon, Brodsky, & Frances, 1994); similarly, there is a strong association between AN and completed suicide (Wisniewski, Safer, & Chen, 2007). Empirically-supported treatments such as cognitive behavior therapy (CBT) are estimated to be effective for only about half of individuals who seek treatment for BN (Whittal, Agras, & Gould, 1999) and for an even smaller percentage of clients with AN (Fairburn & Harrison, 2003). The transdiagnostic flexibility of DBT makes it a viable treatment option for individuals with a primary diagnosis of an ED who do not respond well to traditional CBT as well as for individuals who meet criteria for both BPD and an ED.

There is growing empirical support that DBT is effective for clients with EDs, particularly in the areas of BN and BED (Safer, Telch, & Agras, 2001; Telch, Agras, & Linehan 2001). Several of the standard DBT skills have been adapted for ED clients, including the inclusion of mindful eating, urge surfing, and alternate rebellion. Mindful eating involves the application of mindfulness “what” (observe, describe, and participate) and “how” (one-mindfully, non-judgmentally) skills to the process of eating. The urge surfing skill involves noticing the environmental cues that trigger emotional eating and detaching from the ebb and flow of the urge through active observation. Finally, alternate rebellion can be applied to help individuals find other ways to rebel against society or peers whom they perceive to be judgmental about their weight. Instead of binge eating out of spite, clients are encouraged to find alternate modes of expression that are consistent with their goals and values. While much of this research has been conducted with adults, new evidence suggests that DBT-ED is effective for adolescents as well (Salbach-Andrae et al., 2009).

To improve understanding about the etiology of eating disorders, Wisniewski and Kelly (2003) adapted the biosocial theory of DBT. They posited that in addition to having a biological susceptibility to emotion dysregulation, clients with EDs are also susceptible to a nutrition-related vulnerability that affects the body’s ability to regulate hunger cues. These vulnerabilities are thought to transact with an invalidating environment to create maladaptive behaviors, such as restricting, binge eating, and/or

purging. The invalidating environment may take the form of teasing about weight from family members and peers, cultural pressures that promote an “ideal” weight and size, and media attention on dieting and losing weight (Wisniewski, Safer, & Chen, 2007).

Similar to DBT-SUD, the standard hierarchy of DBT treatment targets can be readily adapted to incorporate behaviors specific to eating disorders. As Wisniewski, Safer, and Chen (2007) highlight, ED behaviors are considered to be life threatening when they pose an imminent risk of threat either to the patient or another person. Examples of life-threatening behaviors include vomiting in the context of severe electrolyte imbalance or restriction in a low-weight patient with bradycardia. Consultation with members of the medical team is advised to help determine whether or not a specific ED behavior qualifies as life threatening. Examples of therapy-interfering behaviors in DBT-ED include not completing food diary cards, difficulties focusing in session due to being overly hungry or glucose deficient, falling below an agreed-upon weight range, purging that negatively affects medication absorption, and lying about weight either directly or through surreptitious means (e.g. water loading prior to weigh-in). Finally, quality-of-life-interfering behaviors specific to ED include restricting, binge eating, vomiting, excessive exercise, diet pill abuse, and other weight-related compensatory behaviors (Wisniewski, Safer, & Chen, 2007). The emphasis of DBT on commitment strategies and therapist support inherent in the consultation team are noteworthy aspects that make DBT relevant in helping this historically difficult-to-treat population. For detailed descriptions of applications of DBT to address eating disorders, including diary card, sample commitment agreements, and therapeutic pointers, see Wisniewski, Safer, & Chen (2007).

Another adaptation of DBT for EDs is the modification of secondary treatment targets. As Wisniewski and Kelly (2003) discussed, a key dialectical dilemma for individuals with ED relates to “out-of-control binge eating” at one extreme and “overcontrolled eating” on the other. Similarly, a dialectical dilemma may also be used to highlight extremes in exercising (no exercise vs. excessive exercise). The balance between these extremes promotes mindful and flexible eating and exercising behaviors. As in DBT-SUD, the concept of dialectical abstinence relates specifically to objective binge eating; its aim is to encourage clients to commit to completely abstain from objective binge eating while at the same time acknowledging that if a binge episode occurs, they can return to the goal of abstinence from overeating and feeling out of control.

DBT FOR COMORBID PTSD (DBT-PE)

While protocol-driven treatments such as prolonged exposure (PE; Foa, Hembree, & Rothbaum, 2007) and cognitive-processing therapy (CPT; Resick & Schnicke, 1993) have empirical support for treating posttraumatic stress disorder (PTSD), research suggests that these treatments by themselves are not as effective in treating more complicated diagnostic presentations of trauma (van der Kolk & Courtois, 2005). Indeed, PTSD, BPD, and nonsuicidal self-injury (NSSI) commonly co-occur in community and clinical samples; Wagner, Rizvi, and Harned (2007) estimated that around two-thirds of individuals with BPD have experienced physical or emotional abuse in childhood, and an even higher percentage report trauma in adulthood. Notably, individuals with comorbid PTSD and BPD have been reported to be significantly more likely to engage in suicidal and self-harming behaviors (Harned, Korslund, Foa, & Linehan, 2012). As a principle-driven therapy, DBT lends itself to addressing these multiple problems as well as the relationships between the problems.

RATIONALE FOR DEVELOPMENT AND TREATMENT STRUCTURE

While research suggests that standard DBT has promise in stabilizing clients who have a constellation of disorders and symptoms, (e.g., BPD, PTSD, and NSSI), this population in particular has historically been challenging to treat. Long-term treatment gains, particularly with respect to PTSD symptoms, may be limited; for example, Harned, Chapman, and colleagues (2008) found that after one year of DBT, the remission rate of PTSD is approximately 35%. In addition, Barnicot and Priebe (2013) found that clients with comorbid BPD and PTSD were less likely to reduce their rates of NSSI compared to clients with BPD alone over a one-year period. Overall, findings suggest that standard DBT may have a limited direct effect on improving symptoms of PTSD.

Within the last several years, DBT researchers have developed and evaluated an integrated treatment to address the challenges in treating the constellation of symptoms of suicidal and self-injuring clients with BPD and PTSD (Harned, Korslund, Foa, & Linehan, 2012; Harned, Korslund, & Linehan, in press; Harned & Linehan, 2008). The treatment includes one year of standard DBT in conjunction with the DBT Prolonged Exposure Protocol (DBT-PE). This combined protocol was designed specifically to target symptoms of co-occurring BPD and PTSD by incorporating DBT strategies with the PE protocol for PTSD (Foa, Hembree, & Rothbaum, 2007). The PE protocol is included once clients have

demonstrated that they are not imminently suicidal, have not made a suicide attempt or engaged in NSSI within the last two months, are able to use skills to tolerate intense emotions without trying to escape from them, and are not engaging in significant therapy-interfering behaviors, such as homework non-compliance. In addition, both the patient and therapist must agree collaboratively that PTSD is the top treatment target. Treatment is typically administered in two separate hour-long individual sessions (with the same therapist) or in one extended 90-minute session of DBT-PE and 30 minutes of DBT (Harned, Korslund, & Linehan, 2014). Notably, the DBT-PE protocol utilizes specific DBT strategies and techniques such as dialectics, irreverence, and validation alongside the standard PE elements of in vivo and imaginal exposure. The integrated treatment also requires that the DBT-PE protocol be discontinued should the patient experience a relapse in self-injurious behavior.

Case studies (Harned & Linehan, 2008), an open trial (Harned, Korslund, Foa, & Linehan, 2012) and more recently, a pilot randomized controlled trial (Harned, Korslund, & Linehan, in press) have suggested that the integrated DBT-PE treatment is feasible to implement and leads to large and significant improvements in suicidal ideation, NSSI, symptoms of PTSD, dissociation, shame, anxiety, depression, trauma-related guilt cognitions, and global functioning. Notably, the pilot randomized controlled trial (RCT) compared standard DBT to DBT-PE and found that a majority of completers in the combined therapy (60% to 100%) showed significant improvement in all of the above-mentioned areas at follow up, while a much lower percentage of participants in standard DBT (20%) maintained sustained, significant improvement. The authors concluded that providing integrated DBT-PE to high-risk BPD clients had a strong impact in decreasing suicidal and self-injurious behaviors across the entirety of treatment.

TREATMENT HIERARCHY

Dialectical behavior therapy emphasizes the behavioral analysis of problematic coping strategies, such as NSSI, as a way to discern the function and context of maladaptive emotion regulation strategies that occur in individual who have suffered trauma. As Wagner, Rizvi, and Harned (2007) highlight, the factors involved in the initial development of a problem behavior may differ from the factors that maintain a problem behavior. For example, a patient may have initially developed dissociative symptoms in the context of abuse or another form of trauma but may currently dissociate to avoid contact with negative emotions. The authors

note that effective treatment requires two foci: (1) current factors that maintain the dissociative behavior and the associated development of emotion regulation skills and exposure to current cues for negative emotion; and (2) *in vivo* and imaginal exposure to the index trauma, which is undertaken after the individual has learned skills to manage negative affect as a way to preclude the recurrence of urges and actions to commit suicide or engage in NSSI.

The biosocial theory helps guide the case conceptualization of clients who present with complex trauma histories. For example, personal threats in the form of physical, sexual, and emotional abuse constitute an invalidating environment and are likely to contribute to pervasive emotion regulation difficulties and ineffective compensatory regulation strategies. In keeping with the biosocial theory, the therapist must incorporate both validation and behavioral skills into the case conceptualization to help address the learning histories and skills deficits of clients with BPD and trauma histories. The case conceptualization, in turn, guides the order in which treatment targets are addressed for clients with comorbid BPD and PTSD.

Given the assumption that problem behaviors such as suicide attempts and NSSI are the result of difficulty tolerating intense and painful emotions, the immediate and extensive processing of traumatic events in the absence of teaching skills to manage these behaviors is contraindicated for these clients (Foa, Hembree, & Rothbaum, 2007; Linehan, 1993a). Indeed, PTSD treatment guidelines note that these types of treatments are not suitable for suicidal clients, and PTSD studies routinely exclude clients who are suicidal or who are engaging in NSSI (Bradley, Greene, Russ, Dutra, & Westen, 2005). Thus, the first stage of DBT focuses on minimizing life-threatening behaviors, increasing skills, and fostering a connection with the therapist. The focus is to help the patient learn to modulate their emotions while maintaining contact with emotion cues. Wagner, Rizvi, and Harned (2007) highlight that while trauma symptoms may initially be targeted to the extent that they contribute to life-interfering behaviors (e.g. NSSI), direct treatment of trauma is reserved for when a patient has the skills to effectively tolerate intense emotional re-experiencing.

RADICALLY OPEN DBT (RO-DBT)

One of the newest adaptations to standard DBT is radically open DBT (RO-DBT; see Lynch et al., this volume; Lynch et al., 2007), which was designed to be a transdiagnostic treatment that focuses on problems

associated with emotional overcontrol. While emotional control is emphasized and valued in many societies and cultures, excessive inhibition has been shown to increase the risk for interpersonal difficulties, social isolation, and persistent mental health problems (Lynch et al., this volume). Overcontrolled individuals are characterized as being very rigid and perfectionistic, avoiding risks and new situations and lacking spontaneity and emotional expressivity. The goal of RO-DBT is to help these individuals flexibly adjust to changing environmental demands.

In comparison to standard DBT, the primary dysfunction treated in RO-DBT is emotional loneliness stemming from social ostracism. Rooted in Linehan's (1993a) biosocial theory, RO-DBT posits that problems with emotional overcontrol result from the transaction between: (a) a biological predisposition to be particularly sensitive to threat and unaffected by social rewards; and (b) environmental experiences that place excessive importance on avoiding mistakes and maintaining self-control. The biological component of the theory suggests that overcontrolled individuals tend to experience heightened threat arousal, which precludes them from feeling safe and comfortable in social interactions. This arousal is associated with increased sympathetic nervous system activity and decreased activity of the facial muscles, resulting in blank or scowling facial expressions that tend to increase the likelihood of social rejection and isolation. Thus, the primary aim in RO-DBT is to teach clients skills that increase their sense of safety in social situations and enable them to express emotions more genuinely and fluidly during social interactions in order to prevent rejection.

Radically open DBT uses the same treatment modalities as standard DBT (i.e., individual therapy, skills training, coaching calls, and consultation team). Similar to standard DBT, the first objective in individual therapy is to reduce life-threatening behaviors. Next, RO-DBT therapists emphasize the repair of alliance ruptures and conceptualize interpersonal conflicts as opportunities for clients to learn that conflicts enhance relationship closeness. Attending to alliance ruptures allows clients to repair relationships, rather than succumbing to the urge to avoid or abandon relationships. Finally, individual therapy aims to decrease maladaptive behaviors related to emotional overcontrol, such as emotional inhibition, behavioral avoidance, rigidity in thoughts and behaviors, emotional distancing in relationships, and negative affect that results from social comparison and failure to achieve personal goals.

In addition to the original four skills modules in standard DBT, RO-DBT incorporates a new module of radical openness skills to address the emotional and behavioral deficits often seen in overcontrolled individ-

uals. The skills taught in the module are designed to increase openness and flexibility to new ideas, decrease avoidance, improve responses to interpersonal feedback, increase trust, empathy and validation of others, and decrease feelings of bitterness and envy through forgiveness and compassion. Unlike the skill of radical acceptance that is taught in standard DBT (wherein individuals are taught to accept reality as it is without trying to change it), radical openness skills help clients to: (a) be more aware of environmental cues that do not fit their beliefs or ideas about how the world works, (b) engage in self-inquiry to challenge typical response patterns, and (c) respond flexibly and effectively based on feedback from the social environment. Such strategies are useful in enhancing cognitive flexibility in overcontrolled individuals who tend to hold rigid beliefs and worldviews.

Radically open DBT incorporates several other adaptations to the skills training modules used in standard DBT. For example, the original states of mind concept was replaced with three new states of mind: fatalistic mind, in which the individual views change as unnecessary “because there is no answer,” fixed mind, in which the individual views change as unnecessary “because I already know the answer,” and flexible mind, in which the individual is open to the possibility of change in order to learn. Of note, wise mind differs from flexible mind in that the former emphasizes intuitive knowledge (“I know to be”), while the latter encourages self-inquiry and the challenging of preconceived ideas. In addition, the mindfulness module of RO-DBT teaches clients to observe the urge to fix or correct as transitory and optional, much as standard

DBT teaches clients to observe urges to act on emotion in unskillful ways and to let the urge pass without action. The emotion regulation module of RO-DBT promotes experience and expression of emotions and actively teaches clients to notice and avoid the urge to mask feelings. Interpersonal effectiveness skills in RO-DBT focus on decreasing social isolation, while self-soothe and radical acceptance are the most relevant distress tolerance skills for overcontrolled individuals.

CONCLUSION

Due in large part to the flexible integration of acceptance and change-based strategies, DBT is an ideal treatment to be modified for transdiagnostic applications. Dialectic behavior therapy relies on effective and accurate case conceptualization strategies that allow the therapist and client to collaboratively address multiple diagnostic and quality-of-life related issues across the course of treatment. In addition, because DBT is

a principle-driven treatment that incorporates as-needed protocols, it seamlessly allows the therapist to dialectically blend the essential elements of DBT (e.g., structural strategies, communication strategies) with empirically supported protocols for co-occurring diagnoses such as eating disorders, PTSD, and SUDs. Moreover, avenues exist to further expand the transdiagnostic reach of DBT by incorporating evidence-based treatments for additional comorbid diagnoses, such as panic disorder. As we have noted elsewhere (Ritschel, Miller, & Taylor, 2013), comprehensive DBT is an intensive treatment requiring considerable training for therapists and a sizable commitment from clients; as such, we are careful to note that we are not suggesting that full package DBT should be used when a more parsimonious, streamlined approach is available and likely to be equally or more effective (e.g., CBT for major depression). However, for individuals with comorbid diagnostic presentations, or whose difficulties are driven by a primary difficulty regulating emotions combined with the repetitive use of ineffective coping strategies, such as disordered eating or substance use, adapted versions of DBT may be just what the doctor ordered.

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