Treating Trauma After Dialectical Behavioral Therapy

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Many individuals who meet criteria for borderline personality disorder have histories of childhood trauma that may have contributed to their difficulty regulating affect. Dialectical behavioral therapy focuses on helping these patients to regulate emotional states and achieve behavioral control in Stage 1 so they can tolerate therapy that is focused on trauma and emotional experiencing in a Stage 2 treatment. Although there are effective, empirically validated treatments for posttraumatic stress disorder and its subclinical presentation, there are also a significant number of patients who find these treatments difficult to tolerate. The author discusses coupling dialectical behavioral therapy, an evidence-based therapy, with internal family systems, a therapy that is both clinically promising and compatible with dialectical behavioral therapy, as a Stage 2 therapy for trauma patients who avoid other modes of treatment.

Keywords: dialectical behavioral therapy, Stage 2 DBT, internal family systems, posttraumatic stress disorder, psychic multiplicity

Dialectical behavioral therapy (DBT) teaches skills for change and acceptance that are indexed to the impulsive and self-harming behaviors described under the diagnosis borderline personality disorder in the DSM–IV–R (American Psychiatric Association, 1994). Self-harm is understood in DBT as an ineffective, costly method of coping with dysregulated emotion; skills learned in DBT offer patients alternatives for managing and regulating emotion as well as more effective ways of being assertive (Linehan, 1993). The ability to tolerate strong emotion without engaging in destructive behavior marks the success of DBT in Stage 1 and is intended to provide a platform for the next stages of treatment (Linehan, 1999).

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For many DBT graduates who have trauma histories the next stage should involve existing empirically validated therapy options for posttraumatic stress disorder (PTSD) and its subclinical presentations. In a multidimensional meta-analysis of psychotherapy for PTSD, Bradley and colleagues found that “a variety of treatments, primarily exposure, other cognitive behavior therapy approaches, and eye movement desensitization and reprocessing, are highly efficacious in reducing PTSD symptoms” (Bradley, Greene, Russ, Dutra & Westen, 2005, p. 225). But research studies related to trauma have high numbers of dropouts (Burstein, 1986; Cloitre, Koenen, Cohen, & Han, 2002; Scott & Stradling, 1997; Tarrier et al., 1999), and Bradley and her colleagues went on to say, “Given the numbers and types of patients who either are not included in these studies (e.g., substance abusers) or do not respond, we need to evaluate alternative or augmented treatments and vary treatment parameters” (Bradley, Greene et al., 2005, p. 225). Of concern in this article are patients who have achieved enough behavioral control in Stage 1 with DBT to warrant turning to trauma but instead avoid or drop out of empirically validated therapy options.

**OVERVIEW**

This article is divided into four sections. The first is a brief review of the movement for psychotherapy integration (PI) and a description of how this proposal fits in. The second describes the theory and methodology of DBT, a Stage 1 treatment for behavioral and emotional dysregulation. The third is a description of internal family systems (IFS) therapy with a case example to illustrate how this treatment processes emotion and trauma. And the fourth presents a rationale for coupling a therapy with an established base in evidence like DBT (with 7 or more randomly controlled trial studies) with a clinically promising therapy like IFS that has one recently completed randomly controlled trial (Shadick, Sowell, & Schwartz, 2010).

**PI**

Most therapies are a product of some sort of integration (Norcross, 2005), including the two described here. In creating DBT, Marsha Linehan yoked two conceptual opposites, change and acceptance, as these are operationalized in cognitive–behavioral therapy and Zen Buddhism. Cognitive–behavioral therapy is based in learning theory and operant conditioning; Zen Buddhism is a spiritual practice relevant for Linehan as an attentional discipline and a tool to promote the acceptance of reality. In
addition to theoretical integration, DBT combined individual and group therapy modalities. Richard Schwartz, who developed IFS, used his experience-near observations of psychic multiplicity to blend systems theory with an intrapsychic model of human motivation, and to merge a multi-person treatment modality along with its techniques (i.e., family therapy) with individual therapy. In addition, Schwartz discovered parallels between the subjective experiences described by his patients and beliefs taught in multiple spiritual disciplines. In sum, Linehan and Schwartz both embraced technical and theoretical integration within the field of psychology and also imported concepts from eminent spiritual traditions.

PI, then, is not a specific treatment, it is rather an approach to the diverse, burgeoning field of mental health that has become increasingly popular in the last three decades (Norcross, 2005; Stricker, 1994). In a history of PI, Norcross (2005) described four main lines of development: technical eclecticism, an actuarial approach that considers what works for whom through the lens of data; common factors, an approach that highlights shared elements of successful therapy (like the therapeutic relationship) across different styles of treatment; theoretical integration, a dialectical approach to theory that looks for new insight and paradigm shifts; and assimilative integration, in which (most frequently) experienced clinicians use clinical acumen to plumb ideas and techniques from multiple sources to integrate into their primary approach.

The design described here is a variation on assimilation involving a sequential integration of complementary equals that delivers two therapies intact, in stages (see Goldfried, Glass & Arnkoff, 2011, p. 286, for a discussion of empirically validated PI treatments taking this tack). As the patient achieves sufficient affect regulation in DBT to be able to focus on trauma, the therapist introduces the patient to concepts shared by DBT and IFS and, during sessions that follow, the therapist points out how these shared concepts are being operationalized experientially for the patient. The goal is to use shared concepts to bridge the learning based approach of DBT in Stage 1 into the next phase of treatment, emotional experiencing. Below are summations of DBT and IFS.

**DBT**

DBT is a comprehensive treatment for the symptoms of emotion dysregulation listed under the *DSM-IV* diagnosis borderline personality disorder (American Psychiatric Association, 1994). DBT has been empirically validated in at least 7 randomized clinical trials (Lynch, Chapman, Rosenthal, Kuo, & Linehan, 2006). It adheres to a weekly protocol of skills
The biosocial theory in DBT focuses on the development of emotion dysregulation because an invalidating environment reinforces biological vulnerability to emotional sensitivity and emotional reactivity (Wagner & Linehan, 2006). While childhood trauma is common in this population, invalidation may also occur due to a poor fit between the style and temperament of the caretakers and the temperament of the child. The biosocial hypothesis is that biological vulnerability combines with environmental invalidation and leads to widespread dysfunction in the child’s ability to regulate emotion. Children learn to respond to their own feelings and opinions with self-reinforcing anxiety, shame, guilt, contempt, disgust, and fear. The symptomatic behavior of patients is viewed as a costly method of avoiding or coping with these painful emotions.

DBT is behavioral in that it differentiates how a behavior began from how it continues, emphasizing the maintenance of problem behaviors due to lack of motivation or capability rather than focusing on etiology (Wagner & Linehan, 2006). DBT teaches skills to change dysfunctional behavior, manage contingencies, restructure distorted thinking, and tolerate negative affect. The word dialectical applies in multiple categories, starting with an overarching accommodation of two apparent opposites: the change skills imported from behaviorism and acceptance strategies imported from Zen Buddhism (Linehan & Schmidt, III, 1995). For our purposes DBT can be summarized as a therapy that operationalizes the Serenity Prayer: God grant me the serenity to accept the things I cannot change, courage to change the things I can, and wisdom to know the difference.

The skills taught in DBT are divided into four units that have varying goals. Distress tolerance teaches patients strategies for reorienting attention and accepting experience that cannot be changed; emotion regulation focuses on understanding emotion and regulating emotional states; interpersonal effectiveness, derived from assertiveness training sources, teaches patients to assess their goals, make requests and say no effectively. Core mindfulness teaches nonjudgmental observation to regulate painful secondary emotions and negative cognition (Lynch, Chapman, Rosenthal, Kuo, & Linehan, 2006). And finally, patients are taught to access a certain state of mind encompassing the ability to think and feel at the same time called wise mind.

As designed by Linehan, patients contract for six months of individual therapy structured around a diary card that tracks problem behaviors and provides information for behavioral analysis (also known as functional or chain analysis) that maps thoughts, feelings and events leading to, and consequences resulting from, the problem behavior. The behavioral analysis is then followed by a solution analysis in which DBT skills are applied to the problem sequence.
While participating in this structured individual treatment, DBT patients also attend a weekly group to learn skills. The patient’s nonjudgmental attention, or mindfulness, is intended to replace experiential avoidance of the kind that reinforces chronic depression (Berking, Neacslu, Comtois, & Linehan, 2009), and is cultivated in individual and group work to nurture curiosity about even the most painful topics.

Typical treatment targets in DBT include suicide, self-harm, substance abuse, risk taking and dissociation as well as self-invalidation, shame, feelings of emptiness, fear of abandonment, hopelessness, and polarized thinking—all of which are understood to be costly behaviors undertaken to avoid or regulate emotional pain. The objectives of DBT include the ability to think dialectically, to feel self-accepting, to tolerate negative and positive emotion, and to express emotion with skill. Linehan divides treatment into four theoretical, sequential stages: “severe behavioral dyscontrol, quiet desperation, problems in living, incompleteness” (Linehan, 1999, p.370), and four corresponding outcome goals: “behavior control, emotional experiencing, ordinary happiness and unhappiness, capacity for sustained joy” (ibid).

The quiet desperation described by Linehan in the second stage of treatment illustrates the multilayered nature of trauma sequelae. Because these sequelae are unlikely to remit without help (Bradley, Greene, et al., 2005), behavioral control is often just the beginning of recovery, yet treatment for PTSD can be hard to tolerate (Feeny, Zoellner & Foa, 2002). When DBT patients get their life-threatening behavior under control but do not continue on “to treat the traumatic and/or unendurable emotional experiencing that precipitates the behavioral dyscontrol in the first place” (Linehan, 1999, p. 372) a return to habitual high-cost strategies that regulate negative affect is a risk. These patients may once again turn up in “hospital emergency rooms, inpatient units and crisis care services... [so that Stage 1] of treatment may need to be repeated” (Linehan, 1999, p. 372). Palatable therapy options for Stage 2 therefore are important to support Stage 1 gains (Levy, 2008). IFS (described below) is suggested here as a Stage 2 therapy for DBT graduates who need but avoid follow-up treatment focused on traumatic experience.

IFS

IFS is based on the observation made by a number of clinicians and researchers (Bloom, 2008; Kluft, 1993; Schwartz, 1995; Watkins & Watkins, 1997) that psychic multiplicity is an easily evoked, nonpathologic human experience. Although the description of IFS that follows will not repeat the words hypothesized, presumed and postulated, this model of cognition derives from clinical observation and remains hypothetical.
Schwartz describes an internal system that any individual can attend to mindfully, consisting of what he calls a Self, whose salient qualities are compassion and curiosity, and multiple parts, that can be conceptualized as subpersonalities, and that become most evident in strong feelings, opinions, or physical sensations. In an internal system that has achieved a measure of harmony, parts will cooperate and cede leadership to the Self, much as musicians in an orchestra look to their conductor. In the view of IFS, traumatic experience initiates a series of internal events that usually include feelings of being helpless and worthless. Protective parts take on the job of exiling the parts (referred to as exiles) that carry these feelings because they can interfere with current functioning.

The presentation of protective parts ranges from supportive to harshly critical and threatening. Protectors can become polarized with other parts, they can urge frightening or dangerous behavior (suicide, homicide, and a wide variety of self-attack), and they can leave little or no access to the sense of balance and wisdom of which human beings are capable. Nevertheless they are viewed in IFS as protective because they intend to defend against and manage the oppressive, distorting beliefs and feelings generated by trauma.

Exiles are vulnerable and tend to be in a perpetual crisis of time: objective, shared reality insists that time has moved forward while subjective experience insists that it has not. For present day functioning (the principle concern of protective parts) exiles can be a huge liability. To contain them, protectors typically take on one of two sequentially defined roles: either the part works to prevent the emergence of the exile’s emotional and physical experiencing (Schwartz calls this the role of manager), or it focuses on suppression of the exile’s emotional and physical experiencing once it has emerged (the role of firefighter). The managerial part forestalls traumatic reexperiencing while the firefighter steps in once prevention has failed.

The clinical excerpt below illustrates certain basic steps in an IFS therapy, including identifying a trailhead (the emotion, physical sensation, or behavior that provides an initial focus in therapy), unblending parts, and accessing the Self. Annotations in this excerpt highlight IFS theory and technique.

CASE EXAMPLE

As a child, Tia and her family lived with her maternal grandfather and his sister. When Tia was six, her great aunt and grandfather inducted her into a sexual relationship with the grandfather that continued until he died in a car crash when she was 15. A very capable student despite bulimia and bingeing on alcohol and
drugs throughout adolescence, Tia went on to law school and distinguished herself. She established a successful career at a competitive law firm, married an Iraq veteran who also had a history of childhood trauma and a drinking habit, and adopted two girls. Her husband stayed home to parent while she supported the family. However, her husband became increasingly paranoid, imposing social isolation on the children, and exploding in anger with little apparent provocation, and Tia finally asked for a divorce and custody. In response he took the girls and disappeared.

Tia became, by her own description, a full-time mental patient, in and out of psychiatric hospitals, flooded with intrusive traumatic memories and nightmares, cutting herself, plagued with thoughts of suicide, drinking and having difficulty getting out of bed. A psychiatrist urged her to go into a DBT program. Although she began in a dissociative fog, with the benefit of good study habits she came regularly and did the homework. After a year she was sober, attended alcoholics anonymous, was not cutting, had a boyfriend, and was teaching one class. On the other hand, she quarreled often with her boyfriend, was tormented with guilt about her lost children, fluctuated between raging at and rescuing her highly irresponsible parents, had no money, and avoided much needed dental care because of flashbacks. She was in that state of quiet desperation. After trying and refusing eye movement desensitization and reprocessing (EMDR) she agreed to try IFS, which she found more tolerable. Below is an excerpt from a session.

**Tia:** I’m walking through the cafeteria at school and I pass this guy who teaches tort law. He has an office next to the one I use. He’s got this look on his face—like he’s angry in a suppressed kind of way—and it makes me feel nauseous. I have this urge to go after him and do something.

**TH:** Do something?

**Tia:** Yes. I really can’t bear it. I have to leave the building because my office is near his and I don’t trust myself not to pop in there and do something stupid.

**TH:** Any concerns about checking on this?

**Tia:** It’s OK.

The therapist invites Tia to locate this urge—the trailhead—physically:

**TH:** Where do you find the urge in your body?

**Tia:** It’s this panic in my gut. It’s like . . . I’m embarrassed to say this. It’s this physical like . . . urge, like a physical push, to run into his office and get on his lap.

Safety is addressed first:

**TH:** Put the part that was pushing you into a safe room inside of you. And you stay on the outside looking in.

**Tia:** Ok.

**TH:** What do you see?

**Tia:** A little girl in a red floral dress. She’s walking around anxiously.
In order to help this little girl part, the patient needs to unblend reactive protectors:

*TH:* How do you feel toward her?
*Tia:* Honestly? She terrifies me.
*TH:* Ask the part that’s terrified to settle back and let you handle this.
*Tia:* It’s not exactly willing to do that.

The therapist remains curious:

*TH:* What is it concerned about?
*Tia:* That she’ll take over. She kind of ruins my life.

The therapist validates the expertise of the protector who refuses to move back:

*TH:* Ok. That’s important. Let’s negotiate with her to make this safe. Is she aware of you?
*Tia:* She’s completely distracted.
*TH:* Don’t go in the room yet but see if the little girl knows you.
*Tia:* Yes she does.
*TH:* Tell her that you want to help her but when she overwhelms you, you’re not there so you can’t help. Does she get that?

Parts that have been exiled are often desperate for connection but nevertheless suspicious:

*Tia:* She doesn’t trust me to stay anyway.

Acknowledging the experience of chronic rejection is very important:

*TH:* Are you ready to hear about that?
*Tia:* Do I have to?
*TH:* Is there a part that’s worried about you hearing about it?
*Tia:* I guess so.
*TH:* What does that part need from you to feel ok right now?
*Tia:* I did it.
*TH:* You took care of it?
*Tia:* Yes.
*TH:* Any other part with strong feelings about the little girl?
*Tia:* I think it’s ok now.
*TH:* How do you feel toward her?
*Tia:* I feel mostly curious.

The therapist continues to work on detecting and unblending reactive parts:

*TH:* What percent of what you feel is curiosity?
*Tia:* Seventy.
*TH:* What’s the other 30?
Tia: Disgust.
TH: Ask the disgusted part to move back and let you help her.
Tia: Ok.
TH: What do you feel now?
Tia: Concern.

Tia is sufficiently Self-led now to help this part:

TH: Let her know.
Tia: She says I’ve always left her alone.

This part has been exiled and does not yet differentiate Tia’s core Self from reactive protectors:

TH: Let her know that it wasn’t you. Protective parts got between you and we’re going to help them stop.
Tia: She doesn’t trust me.
TH: Does that make sense?
Tia: I guess it does.

The therapist again checks for reactive parts, this time by eliciting the little girl’s point of view:

TH: How do you feel toward her?
Tia: I care about her.
TH: Is it ok to go in to the room with her?
Tia: Yes.
TH: How close are you to her?
Tia: Ten feet.

The therapist checks again for reactive parts, this time by eliciting the little girl’s point of view:

TH: Ask her to look you in the eye and let you know what she sees you feeling toward her.
Tia: She sees fear.
TH: Ask the part that’s afraid of her to move out of the room so you can help her.
   Is it willing?
Tia: Ok.
TH: Ask her to look again.
Tia: Now she sees that I care.
TH: How is that for her?
Tia: It’s new. She’s not used to it.
TH: How close are you to her?
Tia: A couple of feet.
TH: And how do you feel toward her now?
Tia: I feel compassion.
TH: What’s that like for her?
Tia: It’s really good.
TH: That’s right. When she doesn’t take you over, you’re there to help. What does she need from you?

Tia: She needs my attention.

TH: It’s great that she can tell you. Where is she?

Tia: She’s sitting on my lap.

TH: What does she need?

Tia: She needs not to be alone.

TH: Of course.

Tia: But she’s afraid I’m going to find out how bad she is—she says: really, really bad.

Since the session is almost over there is no time to address this belief, but the therapist is able to preview the goal of helping parts to let go of—or unburden—toxic beliefs and feelings:

TH: Somehow she came by that belief. She can show you how when we meet again.

And then, when she’s ready, she’ll be able to let it go. Where would she like to stay between now and then?

Tia: She wants to be in her tree house with her cat.

TH: And if she wants your attention how will she let you know?

Tia: She says she’ll lean out and blow on my head.

TH: And if you’re busy?

Tia: I’m telling her that I’ll get back to her later.

Recapping the IFS techniques used in the session: Tia reported a trailhead and the therapist invited her to locate a part in her body. The part was an exile that evoked strong reactions from other parts. The therapy process first moved to unblend the protective parts that reacted to this exile with alarm, shame, and disgust so that Tia could access her Self. However, for these protective parts to remain unblended, the exile also had to unblend. As the exile felt Tia’s nonjudgmental interest (or, Self, similar to wise mind in DBT) and became willing to be with her rather than taking her over, the protective parts settled back. In response, Tia became more curious (had more access to Self) and finally felt compassion, bringing the exile to a confession of badness that would be pursued (and finally released) in subsequent sessions.

DISCUSSION

Sequential Integration: Layering and Linking

Although DBT and IFS derive from distinct conceptual heritages and use different language, both were created by clinician/theorists interweaving broad mental disciplines (psychology with spirituality) and specific conceptual training (learning theory, systems theory) with varying treatment modalities (group with individual). The proposal here unites these
treatments sequentially with the goal of helping the patient cement what they hold in common while extending a learning-based approach into emotional experiencing. This design developed from clinical imperative. It is not a pure example of assimilation (grafting various treatment options onto a primary theory base) or of synthesis (theoretical integration); rather, it is a model that layers and links two primary therapies.

Contrasting and Comparing DBT and IFS

At first glance these treatments show clear differences. The skills group in DBT is didactic, it is structured and relies on a contract, time limits, a hierarchy of treatment targets, a weekly diary card to track those behaviors, and behavioral analyses to discover how the target problem is reinforced in the present. In contrast, as illustrated, IFS teaches a relatively simple, straightforward method for attending to and interacting with internal experience.

Nevertheless, DBT and IFS have many parallels, superficial and profound. Sessions are focused and organized by locating a specific source of distress at the outset: The trailhead of IFS is similar to the problem behavior or treatment target used for a behavioral analysis in DBT. After narrowing and specifying the focus of the session, both treatments teach the patient to observe and accept the phases of emotional experience without judgment: the physical, the mental, and the urge to act. Nonjudgmental noticing is geared to replace secondary emotional reactions like fear, anxiety, guilt, contempt, disgust, and shame that habitually inhibit primary, activating feelings like self-assertion, anger, sadness, grief, positive self-regard, intimacy, compassion, and love.

In addition, in DBT the behavioral analysis from individual sessions and the didactic processing of the skills group both engage the patient cognitively and serve to counterbalance intense negative feeling states that block the patient’s ability to think while feeling. Similarly, IFS cultivates a subjective sense of separation from strong, dysregulating emotion by evoking curiosity—and ultimately compassion—within a steady cognitive state of open-minded interest. In sum both treatments rely on the power of attentive curiosity to regulate affect, particularly the most daunting of feelings of contempt, disgust, and shame.

Beyond these similarities, DBT and IFS both work with the existence of multiple (internal and external) viewpoints to modify polarized thinking. DBT teaches the concept of dialects and inclusive thinking. IFS invites direct interaction with and between the internal parties (parts) in conflict for the same reason. Assessed by style, DBT is more cognitive and IFS
more affective yet they correspond in their focus on balance. The wise mind of DBT covers much the same territory as the Self of IFS: Each of these states of mind exploits the mutual exclusivity of strong emotion with curiosity and compassion, and places the ultimate authority for decision making inside the patient. This synchronous view of the road to mental health places DBT and IFS on a natural continuum.

CONCLUSION

DBT has done well in addressing the historic pessimism of therapists about patients who meet criteria for the diagnosis borderline personality disorder. Linehan has been an energetic cheerleader, helping to develop that factor common to effective therapies “expectations of therapeutic success” (Weinberger, 1995, p. 46). DBT has been empirically tested and broadly disseminated; clinicians and researchers continue to explore and expand its applications; gains are measured, studies published and patients generally profit. But for a significant portion of patients who have trauma histories important questions remain about outcome. What percent of DBT graduates continue to experience full-blown or subclinical PTSD? How many of these individuals receive treatment for trauma after DBT and with what success?

There is much to be learned. In the meantime, conceptual continuity spanning two treatments that cover different stages of recovery has advantages, including the familiarity of important concepts (after translation) and the solidification of earlier learning. This article aims to encourage therapists who are searching through treatment options for the DBT graduate who is ready for emotional experiencing to consider IFS therapy.

REFERENCES


