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Chapter 2

Utilizing Dialectical Behavior Therapy and Eye Movement Desensitization and Reprocessing as Phase-Based Trauma Treatment: A Case Study Series

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Abstract

Since clients often initiate outpatient mental health therapy related to a combination of past and present-day concerns, Phase-based Trauma Treatment aims to assist adults affected by psychiatric disorders and/or

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substance abuse who have a history of multiple traumas (child abuse, witnessing domestic violence during childhood, sexual assault, and/or intimate partner violence). This phase-based trauma treatment focuses on assisting clients to regulate emotions and behavior, decrease psychiatric symptomatology, improve relationships, resolve past traumatic events, move toward a healthier and more secure attachment status, and cope more effectively with significant present-day stressors. The purposes of this chapter are to describe, provide rationale for, and illustrate a phase-based trauma treatment program that integrates Linehan's Dialectical Behavior Therapy (DBT) (1993) and Shapiro's Eye Movement Desensitization and Reprocessing (EMDR) (2001), and consists of (a) a year long, initial skills-training phase utilizing DBT followed by (b) a second phase of 18 individual sessions of EMDR. More specifically, the chapter will discuss the need for trauma treatment that addresses both the effects of developmental and attachment deficits on present-day functioning and resolution of past trauma. Three case studies illustrate the effectiveness of Phase-based Trauma Treatment by reviewing both the results on five objective outcome measures and the Adult Attachment Interview as well as client self-reports. Post-DBT results show improvement in affect and behavior regulation, relationships, psychiatric symptomatology, and ability to cope with present-day stressors. Post-EMDR effects indicate that participants maintain or continue improvement in the above-mentioned areas as well as show positive changes in trauma-related symptoms and attachment status. Implications for clinical practice and future research are explored.

Keywords: Child abuse, sexual assault, domestic violence, attachment, treatment effectiveness

Introduction

The impact of childhood traumatic events on emotional development and adulthood emotional and relational functioning are profound, the risk for repeating the cycle of violence and abuse in relationships with partners and in relationships with children is high, and the effectiveness of single, traditional methods of treatment has been quite limited. Since clients often initiate outpatient mental health therapy to improve present-day problems and psychiatric symptoms as well as resolve past traumatic events, a more comprehensive treatment or an integration of treatment strategies may be needed to effectively address both sets of issues. The case study series in this chapter illustrates the positive results from an integrated therapy approach to

clients with complex issues utilizing Linehan's Dialectical Behavior Therapy (DBT, 1993) and Shapiro's Eye Movement Desensitization and Reprocessing (EMDR, 2001).

Effects of Abuse and Trauma

Attachment and Development

Peter Fonagy (1997) posits that the ability to reflect upon one's internal state develops only within a secure childhood attachment relationship and that the inability to resolve past abuse is the result of the inability to self-reflect associated with early insecure attachment relationships. Research utilizing the Adult Attachment Interview (Hesse, 1999) and the Strange Situation Assessment (Ainsworth, 1978; Main & Solomon, 1990) has found that when mothers hold unresolved memories of loss or childhood abuse, their children typically develop disorganized and/or insecure attachments. The children's disorganized attachment may be a consequence of their mothers' emotional dysregulation and poor attunement. Mothers with unresolved attachment loss or abuse are also at-risk for becoming overtly abusive to their children (Lyons-Ruth & Jacobvitz, 1999).

Dozier et al. (1999) report that the attachment literature consistently found psychiatric disorders to be predominantly associated with insecure attachment styles in adulthood, i.e., preoccupied, dismissive, and/or unresolved. Furthermore, Dozier and colleagues state, "unresolved (attachment) status is the most overrepresented state of mind among persons with psychiatric disorders" (p. 515). Unresolved attachment status in adulthood is directly related to unresolved attachment trauma and loss, and is also related to disorganized attachment in infancy. Disorganized attachment status is associated with dissociation as well as vulnerability to psychiatric disorders (Hesse, 1999). Research has shown that approximately 80% of abused children have a disorganized attachment style (Lyons-Ruth, 1991). Van der Kolk (1996) explains that the ability to self-soothe is learned only through the secure attachment relationship, and that psychiatric patients' inability to self-soothe resulting from early abuse or neglect by caregivers leads to affect dysregulation, associated with self-destructive behaviors employed "to regain control over their problems with affect regulation" (p. 188).

Psychiatric Problems in Adulthood

Individuals with histories of trauma have significantly higher rates of major depression, more severe depressive symptoms, and a greater likelihood of experiencing chronic depression (Braver, Bumberry, Green, & Rawson, 1992; Zlotnick, Warshaw, Shea, & Keller, 1997). Mueser et al. (1998) found that 98% of the psychiatric inpatients in their sample reported trauma at some point in their lives. When studies focused specifically on histories of childhood physical and sexual abuse, the rates were reported to range from 28% in psychiatric outpatients (Wexler, Lyons, Lyons, & Mazure, 1997) to 72% in female inpatients (Bryer, Nelson, Miller, & Krol, 1987). Rodriguez, Ryan, Kemp, and Foy (1997) discovered that of the women in their sample who were being treated for childhood sexual abuse, 86.7% met the criteria for PTSD. In a study of 85 psychiatric inpatients, those who met the criteria for borderline personality disorder reported a higher prevalence of childhood sexual or physical abuse, lower capacity to self-reflect, and lack of resolution of the abuse. Additionally, 89% of the women being treated for childhood sexual abuse also reported experiencing physical abuse during childhood. Unresolved childhood trauma interferes with the development of healthy attachment style and can lead to educational underachievement, delinquent behaviors, substance use, and sexually acting out behavior in adolescents (Cooper, Shaver, & Collins, 1998) and psychopathology and criminal behavior in young adults (Allen, Hauser, & Borman-Spurrell, 1996).

Few studies have examined the occurrence of Post-Traumatic Stress Disorder (PTSD) in persons with psychiatric disorders. However, some reported rates of PTSD among this population range from 42-48% (Mueser et al., 1998; Switzer et al., 1999). Neria et al. (2002) reported that of people who were being hospitalized for the first time due to psychotic symptoms, 68.5% revealed exposure to traumas; 49.2% to a life-threatening traumatic event, 32% to ongoing traumas, 29.1% to multiple (three or more) traumas, and 32.2% to childhood victimization. Of those people who reported traumatic exposure, 26.5% had a lifetime rate of PTSD with women being twice as likely to meet the criteria for PTSD as men. Participants with ongoing trauma were more than four times more likely to have PTSD than those with single traumas. As well, those who were younger, had multiple traumas, or were victimized in childhood were 2.5 times more likely to have PTSD than participants who did not have those factors.

PTSD appears to be a common comorbid disorder for persons with psychiatric disorders. Mueser et al. (1998) found that the rate of PTSD was highest in patients with depression (58%) and borderline personality disorder

(54%), followed by other diagnoses (47%), bipolar disorder (40%), and all other personality disorders (40%), and was lowest among patients with schizoaffective disorder (37%) and schizophrenia (28%). Weaver and Clum (1993) reported that significantly more individuals with borderline personality disorder revealed histories of sexual abuse, physical abuse, and witnessed violence. Mueser et al. (1998) also showed that of the 98% for patients with severe mental illness who had experienced at least one traumatic event, the rate of PTSD was 43%, yet only 3 out of 119 patients (2%) had PTSD as a diagnosis in their charts.

Failure to diagnose PTSD as a comorbid disorder may have significant implications for the treatment of persons with psychiatric disorders. Untreated PTSD could contribute to vulnerability to substance abuse, relapse of psychiatric symptoms, a worsened course of severe psychiatric disorders, social isolation, loss of social support, and employment problems (Mueser et al., 1998). Mueser and colleagues (1998) note that

Trauma has been related to a variety of negative outcomes in persons with severe mental illness. Patients with trauma histories tend to have more severe symptoms, are more likely to have substance abuse disorders, and tend to use higher end psychiatric services, such as hospitalizations (p. 493).

Patients with childhood abuse histories develop symptoms and enter the psychiatric system at a younger age, have more frequent and longer hospitalizations, and more often receive psychotropic medications. Patients who reported childhood sexual abuse were 3.5 times more likely to have been sexually assaulted as adults (Read, Agar, Barker-Collo, Davies, & Moskowitz, 2001).

Kidd, Ford, and Nasby (1996) studied 84 of 85 consecutive admissions to a Veteran's Inpatient Program with a history of high utilization of intensive psychiatric care and found that the veterans least likely to respond to treatment reported early childhood abuse experiences and exhibited symptoms associated with Complex PTSD or "Disorders of Extreme Stress Not Otherwise Specified" (DESNOS) (Herman, 1992; Roth et. al, 1997; van der Kolk et al., 1996), and did not necessarily meet criteria for PTSD. The history of early childhood abuse was associated with DESNOS symptoms including extreme affect and impulse dysregulation, dissociation and somatization, and altered beliefs concerning self and relationships; symptoms which appeared to prevent a positive response to treatment.

Intimate Partner Violence

A history of abuse by childhood attachment figures also increases the likelihood of becoming involved in domestic violence experiences in adulthood for both sexes (Carrol, 1980; Gelles, 1974; Ornduff, 2001). Research by Corvo (2004) suggests dual pathways to intimate partner violence in adulthood: childhood victimization and attachment disruptions. At the same time, the presence of domestic abuse in the family raises the risk of child abuse perpetrated by both offending and non-offending partners. Among 400 residents of shelters for women survivors of intimate partner violence, Walker (1984) found that 53% of the male partners and 28% of the women were abusing their children. Intimate partner abuse precedes child abuse in over two-thirds of cases. For example, women survivors of intimate partner violence were at least twice more likely to abuse their children physically than were women who were not abused. There is an 80% decrease in maltreatment after mothers leave their abusers (Strauss & Gelles, 1990).

In a 15-year follow-up study of a home visitation project with poor, adolescent mothers in upstate New York, it was found that although home visitation decreased incidents of child maltreatment overall, the intervention did not decrease maltreatment by the mothers involved in abusive partner relationships (Eckenrode et al., 2000). One reason for the increase in maltreatment by both parents in situations of domestic abuse may be that parents who experience domestic violence during the first year of their child's life develop a significantly more negative view of their child than other parents (McGuigan, Vuchinich, & Pratt, 2000). Perhaps affect regulation difficulties of both the non-offending and the offending parent prevent attunement and the formation of affectionate bonds with their children.

Affect Regulation

Emotion dysregulation and problems with impulse control and unstable relationships are common adulthood symptoms associated with childhood abuse by attachment figures (Fonagy, 1997; Perry, 1997; van der Kolk, 1996). As well, Ford and Kidd (1998) found high rates of treatment failure when working with victims of childhood abuse by attachment figures as compared to victims of recent traumas. However, dialectical behavioral therapy (DBT) has been shown to be effective in treating the emotion dysregulation underlying severe psychiatric symptomology, insecure attachment status, and developmental deficits, whereas eye movement desensitization and reprocessing (EMDR) has been proven beneficial in treating individuals with histories of traumatic experiences. Phase-based trauma treatment offers a

sequential combination of these two modalities; DBT as an initial skills-training phase followed by EMDR in the second phase. This combination of therapies could prove beneficial as treatment for adults with psychiatric diagnoses and or substance abuse; histories of childhood trauma, disturbed attachments, emotional developmental deficits, sexual assault, and/or adulthood intimate partner violence; and significant present-day stressors.

Treatment Approaches

Dialectical Behavior Therapy (DBT)

DBT is a systematic cognitive-behavioral method for teaching mindfulness, emotion regulation, interpersonal effectiveness, and distress tolerance skills. Linehan (1993) developed DBT as a psychosocial treatment modality for clients with borderline personality disorder (BPD). According to Linehan (1993), DBT involves two sequential primary phases, skills training and trauma resolution, and emphasizes a hierarchical structure of treatment goals that progresses from reduction of self-injurious and life-threatening behaviors, to the reduction of therapy-interfering behavior and of behaviors that interfere with quality of life, and then to the resolution of behaviors and symptoms related to past traumatic events.

To date, published studies examining DBT have been limited to outcomes following the first phase of treatment (i.e., skills training) and those studies have primarily assessed behavioral functioning in terms of self-injurious behaviors, hospitalizations, suicidal gestures, and therapy-interfering behaviors (Bohus, Haaf, Stiglmayr, Pohl, Bohme, & Linehan, 2000; Koons et al., 2001; Linehan et al., 2002). In a variety of studies, DBT has been found to be more effective than “treatment as usual” with patients exhibiting BPD and other severe psychiatric diagnoses in reducing problematic behaviors including self-harming and impulsive behaviors, substance abuse, depression, dissociation, anxiety, as well as improving social adjustment, anger management, and global functioning (Bohus et al., 2000; Koons et al., 2001; Linehan et al., 2002; van den Bosch, Verheul, Schippers, & van der Brink, 2002; Verheul, van der Bosch, Koeter, de Ridder, Stijnen, & van der Brink, 2003). However, there is a scarcity of literature investigating the effectiveness of the second phase of treatment (i.e., trauma resolution) and none examine the efficacy of phase-based trauma treatment utilizing a combination of DBT followed by EMDR.

Eye Movement Desensitization and Reprocessing (EMDR)

EMDR involves a standardized set of procedures and clinical protocols used to resolve disturbing emotional material secondary to traumatic or disturbing events (Shapiro, 2001). Processing of the traumatic material is facilitated by specific types of bilateral sensory stimulation including left-right, bilateral eye movements, tones, and kinesthetic stimulation while accessing the stored information, allowing the client to experience simultaneously the distressing memory and the present context. EMDR therapy involves eight specific phases; (a) history-taking, (b) preparation, (c) assessment, (d) desensitization and reprocessing of the associated images, affect, cognitions, and sensations, (e) installation of a positive cognition, (f) body scan, (g) closure, and (h) re-evaluation. EMDR treatment targets past memories as well as current triggers, and installs templates for imagined future adaptive behaviors.

Approximately 20 randomized controlled studies have shown EMDR to be an effective treatment for the reduction of symptoms related to traumatic or distressing experiences and client concerns presented when initiating therapy as well as increases in positive cognitions and affect (e.g., Chemtob, Tolin, van der Kolk, & Pitman, 2000; Edmond, Rubin, & Wambach, 1999; Edmond, Sloan, & McCary, 2004; Marcus, Marquis, & Sakai, 1997; Rothbaum, 1997; Scheck, Schaeffer, & Gillette, 1998; van der Kolk et al., 2007; Wilson, Becker, & Tinker, 1995, 1997). Bisson and Andres (2007) found EMDR to be effective in treating traumatic stress in seven studies comparing EMDR to cognitive treatments.

More recently, researchers have begun investigating the utility of EMDR in improving attachment working models. Although there is little published literature in this specific domain to date, Wesselmann and Potter (2009) presented case studies highlighting the ways in which 10 to 15 sessions of EMDR effected positive change in attachment status for participants who began treatment with insecure or disorganized attachment categorizations. As well, Madrid, Skolek, and Shapiro (2006) reported the effectiveness of using EMDR to repair attachment/bonding failures between mothers and their children.

Case Study Series

The three case studies in this chapter illustrate the impact of a phase-based trauma treatment protocol including both DBT and EMDR. This treatment

protocol was aimed at assisting adults who had a history of complex trauma (multiple traumas including child abuse, witnessing domestic violence during childhood, sexual assault, and/or intimate partner violence) to regulate emotions and behavior, move toward a healthier and more secure attachment status, decrease psychiatric symptomatology and potential for continuing the cycle of violence with partners and children, and resolve significant present-day stressors.

Method

Procedures

Data for the case studies were collected from three clients seeking treatment at a non-profit agency providing trauma treatment to an underserved population of adults in a Midwestern city. All three clients in this case study series were diagnosed with psychiatric disorders and/or substance abuse problems in addition to their histories of childhood abuse (physical, emotional, sexual abuse and/or witnessing domestic violence) and adulthood sexual assault and/or intimate partner violence. The clients participated in a phase-based trauma treatment program that included (a) a year-long, initial skills training phase utilizing DBT followed by (b) a second phase of EMDR. More specifically, phase one, DBT, involved twelve months of weekly 2-hour class sessions in which each of the four modules of Mindfulness, Distress Tolerance, Emotion Regulation, and Interpersonal Effectiveness were taught twice. Additional coaching in the use of skills was provided through weekly 50-minute individual sessions. Phase two, EMDR, involved processing of traumatic memories during 18 individual sessions.

Measures

Prior to treatment commencing, participants were assessed individually using the Adult Attachment Interview, a demographic survey, and a set of pre-intervention measures (see Instruments). The Adult Attachment Interview and the outcome measures were then administered following completion of phase one, DBT, as well as at the conclusion of phase two, EMDR. Treatment therapists and the first author reviewed clients' weekly diary cards that monitored progress in decreasing problem behaviors and increasing use of skillful behaviors. The first author also reviewed clients' files following the completion of treatment.

Adult Attachment Interview

The Adult Attachment Interview (AAI; George, Kaplan, & Main, 1996) is an interview protocol with 18 questions and specified follow-up probes to assess attachment style and the resolution of loss and/or trauma related to primary childhood caregivers. According to Main and Goldwyn (1998), a standardized coding system developed by Main et al. (1998, 2002) is utilized in which a trained and certified coder rates the transcribed interviews on 9-point scales pertaining to past experiences with attachment figures and current state of mind regarding attachment with respect to coherence at the linguistic level. In general, interviews that are highly coherent are rated as Secure, whereas interviews with poor coherence are rated as either Preoccupied or Dismissive. A Preoccupied attachment status reveals participants who become lost in attachment-related discourse during the interview due to feelings of anger or fear. Because Dismissive participants tend to avoid attachment-related material, their interview discourse lacks emotion. The sections of the interview related to losses and experiences of abuse by parents are rated regarding level of disorientation or severity of behavioral reactions to determine if the participant meets criteria for an Unresolved/Disoriented classification with respect to the loss or abuse. The Unresolved/Disoriented designation is always in addition to a Secure, Preoccupied, or Dismissive classification.

Objective Outcome Measures

The 32-item *Behavior and Symptom Identification Scale* (BASIS-32; Eisen, 1996) uses a 5-point, Likert scale to assess a person's perceived degree of difficulty with a range of problems and symptoms experienced during the past week. The subscales are Relation to Self and Others, Depression and Anxiety, Daily Living and Role Functioning, Impulsive and Addictive Behavior, and Psychosis. The 63-item *Inventory of Altered Self-Capacities* (IASC; Briere, 1998) uses a 4-point, Likert-type scale to measure the frequency of occurrence of difficulties in affect regulation, relatedness, and identity. Seven scales comprise the IASC: Interpersonal Conflicts, Idealization-Disillusionment, Abandonment Concerns, Identity Impairment, Susceptibility to Influence, Affect Dysregulation, and Tension Reduction Activities.

The 104-item *Detailed Assessment of Post-traumatic Stress* (DAPS; Briere, 2001) uses a variety of response formats to assess current and lifetime history of trauma exposure, peri- and posttraumatic symptoms and related features specific to a traumatic event, and the severity of symptoms including

dissociative, cognitive, and emotional responses. The DAPS scales include three PTSD symptom clusters of Reexperiencing, Avoidance, and Hyperarousal, as well as three PTSD associated features of Trauma-Specific Dissociation, Suicidality, and Substance Abuse. The 160-item *Child Abuse Potential Inventory* (CAPI; Milner, 1986) utilizes a forced-choice format to screen for physical child abuse by adult caretakers. The CAPI is comprised of a physical abuse scale, six abuse factor scales (Distress, Rigidity, Unhappiness, Problems with Child and Self, Problems with Family, and Problem with Others), and three validity scales (Lie, Random Response, and Inconsistency), and two special scales (Ego-strength and Loneliness).

The 344-item *Personality Assessment Inventory* (PAI; Morey, 1991) uses a 4-point Likert-type scale to assess symptoms related to mental illness and substance abuse problems, and assigns DSM-IV diagnoses based on their responses. The PAI is comprised of 22 non-overlapping scales that include four validity scales, eleven clinical scales, five treatment scales, and two interpersonal scales.

Case Study Participant #1: Ms. A

Presenting Complaints and History

Ms. A., a 37-year-old white female, was a college graduate with a yearly income of less than \$10,000. She was living with a partner, had no children, and was not disabled or homeless. She came to treatment having identified issues with impulsivity (e.g., spending money), food and weight, emotion dysregulation, underemployment, and unhealthy relationships including incidents of intimate partner violence. She reported a history of depression, suicide attempts, drug and alcohol abuse including cocaine overdoses, and self-harm behavior (e.g., cutting). She reported that she had been clean and sober for eight years. At the beginning of treatment, Ms. A.'s psychiatrist diagnosed her with Major Depressive Disorder, recurrent, moderate; Borderline Personality Disorder; and Posttraumatic Stress Disorder.

Ms. A. was raised by a father with addictions to prescription drugs and alcohol and a mother who was alcoholic. Her mother "disappeared" for intervals up to a few weeks at a time during her childhood and adolescence, and she lived with her grandfather at times. Ms. A. stated she witnessed domestic violence of her mother by her father, witnessed physical abuse of her brother by her father, and was raped as a teenager by boys from her church.

Her losses included her parents' divorce, a grandfather's death, a paternal uncle's death related to drugs and alcohol, an aunt's suicide, and a close friend's suicide when she was fourteen.

Assessment and Course of Treatment

Prior to starting the DBT skills training phase of treatment, Ms. A. had invalid test results on the PAI due to over-reporting negative symptoms. She was slightly below clinical range on the DAPS Posttraumatic Stress Subscale (PTS), but had scores in the clinical range on the scores of the BASIS-32 Total, BASIS Relation to Self and Others, IASC subscales, and CAPI Abuse Potential. On the AAI, she appeared to be Dismissive in attachment style and Unresolved with respect to loss or abuse from parents.

During the twelve months of DBT skills training, Ms. A. focused on decreasing her use of targeted behaviors such as cutting, spending, and overeating; increasing effective skills' usage especially in relationship with her partner; and regulating her emotions. Following one year of DBT skills training, Ms. A. exhibited an Adjustment Disorder diagnosis according to the PAI. Ms. A.'s scores on the BASIS-32 Total and BASIS-32 Relationship to Self and Others Subscale improved measurably, but remained in clinical range. Her score on the DAPS PTS did not improve. She improved on the IASC Affect Dysregulation and Interpersonal Conflicts Subscales, with the Interpersonal Conflicts falling below clinical range. Her CAPI Abuse Potential score improved but remained in clinical range. On the AAI, her score showed an Earned Secure designation without evidence of the Unresolved category. Her diary cards showed decreases in the frequency of targeted behaviors such as cutting, spending, and overeating, and increases in the frequency of effective skills' usage as well as more regulated emotions. Additionally, she reported more assertiveness in her intimate relationship.

Adhering to the eight-stage EMDR protocol, her therapist assisted her in linking present-day behaviors and triggers with negative cognitions or core beliefs related to past traumatic events. Her primary negative cognitions were: (a) I am unlovable/I am not important/I am not enough, (b) I can't do anything right, and (c) What happened to me was my fault. Ms. A. began to view her present-day problematic behaviors in light of negative cognitions or negative core beliefs that were linked to specific past traumatic events such as sexual assaults, her parents' reactions when she disclosed the sexual assaults, witnessing physical abuse of her brother by her father, her friend's suicide when she was fourteen, her father's physical violence towards her mother, not being able to find her father during one of her mother's "disappearances," and

one of her cocaine overdoses. Her therapist helped Ms. A. develop a Safe Place and the internal resources needed to proceed with EMDR.

Throughout 18 EMDR sessions, she was able to process traumatic memories and the associated negative cognitions, affect, and sensations to distress levels between zero and one (on a 0-10 scale where zero is no distress), as well as develop and strengthen alternate positive cognitions and sensations to levels of six to seven (on a 1-7 scale where seven is the strongest positive belief), such as: (a) I am a gift, (b) I have my own authentic feelings, (c) I am responsible for my own reactions, and (d) I choose to be in relationships with people who are able to care about me. She was able to desensitize present-day triggers to past traumas as well as install future adaptive behavior templates.

At post-EMDR assessment, Ms. A.'s Adjustment Disorder diagnosis resolved, her Basis-32 scales, IASC Affect Dysregulation scale, and CAPI Abuse Potential improved from clinical levels to within normal limits. Her DAPS score and IASC Interpersonal Conflict scale maintained below the clinical cut off, and her attachment status on the AAI remained Earned Secure with no evidence of Unresolved category with respect to loss or abuse by parents. Her diary cards showed continued improvement in skills' usage and she reported to her therapist that she stopped cutting, ended her unhealthy intimate relationship, and had started her own business. See Table 1 for specific scores across assessment intervals for Ms. A.

Table 1. Test Scores and Attachment Status for Case Study #1: Ms. A

Case Study #1: Ms. A.	Pre-DBT	Post-DBT	Post-EMDR
PAI Diagnosis	Invalid Results	Adjustment Disorder NOS	None
BASIS-32 Total	1.7*	1.03*	.60
BASIS-32 Relation to Self and Others	3.0*	1.86*	.86
DAPS PTS	54	52	46
IASC Affect Dysregulation	100*	79*	52
IASC Interpersonal Conflicts	88*	46	44
CAPI Abuse Potential	325*	231*	88
AAI	Dismissive/Unresolved	Earned Secure/no evidence of Unresolved	Earned Secure/no evidence of Unresolved

Note. * = clinical level.

Participant #2: Ms. B

Presenting Complaints and History

Ms. B., a 40-year-old white female, was a college graduate and a full-time student. Her reported yearly income was between \$10,000 and \$20,000. She was divorced without children and was neither disabled nor homeless. She came to therapy wanting to work on issues of emotion dysregulation; impulsivity; mood-dependent behavior; amotivation; difficulty keeping jobs; poor relationship boundaries; weight, food, and exercise; and performing activities of daily living (e.g., keeping herself and her living space clean). She reported a history of drug and alcohol abuse, but indicated that she had been clean and sober for twenty years. Ms. B. also reported a suicide attempt at the age of eleven and depression for which she was currently being treated with medication. At the beginning of treatment, Ms. B.'s psychiatrist had diagnosed her with Dysthymia and Posttraumatic Stress Disorder.

Ms. B. stated that her parents were alcoholic and that her mother drank while pregnant. She reported witnessing domestic violence of her mother by her father while growing up. In terms of her relationships with her parents, she stated that her mother was verbally and emotionally abusive as well as neglectful, and that her father was verbally and physically abusive toward her. Ms. B. also stated that her father was "sexually inappropriate" with her by exposing her to pornography. Additionally, she specified ongoing bullying by her siblings. Regarding adult relationships, Ms. B. reported physical, verbal, and emotional abuse by her ex-husband and other partners. Her losses included an aunt's suicide and her parents' divorce when she was seven years old.

Assessment and Course of Treatment

Prior to beginning the DBT skills training program, Ms. B. met criteria for both Relational Problems NOS and Borderline Personality Disorder on the PAI and she scored in the clinical range on all measures except for the CAPI Abuse Potential. She appeared to have an Earned Secure attachment designation with no evidence of the Unresolved category with respect to loss or abuse by parents on the AAI.

During the twelve-months of DBT skills training, Ms. B. focused on decreasing the use of targeted behaviors such as impulsivity, amotivation, lack of self-care regimes, and poor relationship boundaries; increasing effective skills' usage; and regulating her emotions and mood. At post-DBT assessment, Ms. B. did not meet criteria for a psychiatric diagnosis according to the PAI. She showed measurable improvement on all the assessments, and specifically

moved into the non-clinical range on all scales except for the BASIS-32 Relation to Self and Others subscale. In terms of attachment status, she appeared Dismissive on the AAI.

Preparing for EMDR according to protocol, Ms. B.'s therapist helped her bridge between her present-day behaviors and triggers with negative cognitions or core beliefs related to past traumatic events. Her primary negative cognitions were: (a) I am bad/I don't matter/I'm not good enough, (b) I caused bad things to happen/My parents' neglect and abuse were my fault, and (c) I can't trust people. Her negative cognitions linked to specific past traumatic events such as witnessing her father's physical violence toward her mother, saying goodbye to her father after her parents divorced, exposure to her father's pornography, answering the front door to the husband of a woman with whom her father was having an affair, and her drunk father making a suicide gesture. Her therapist helped Ms. B. develop a Safe Place and the internal resources needed to proceed with EMDR.

Throughout the 18 EMDR sessions, Ms. B. was able to process traumatic memories and the associated negative cognitions, affect, and sensations to distress levels between zero and one (on a 0-10 scale where zero is no distress), as well as develop and strengthen alternate positive cognitions and sensations to six or seven (on a 1-7 scale where seven is the strongest positive belief) such as: (a) I am lovable/I am important, (b) I was a kid trying to take care of myself/My parents were responsible for their problems/My feelings were appropriate, and (c) I trust my perceptions/I can learn and grow. She was able to desensitize present-day triggers to past traumas as well as install future adaptive behavior templates.

At post-EMDR assessment, Ms. B.'s PAI results showed an Adjustment Disorder NOS. Her scores on the Basis-32 continued to show improvement and on all other measures remained within normal limits. Her AAI attachment status moved from Dismissive with no evidence of Unresolved category to Earned Secure with no evidence of Unresolved category related to loss or abuse by parents. Ms. B.'s diary cards showed continued improvement in skills' usage and she reported to her therapist that she improved her self-care patterns, moderated her eating habits, had begun to be more physically active, ended her unhealthy relationship, and started working again full-time as a nurse. See Table 2 for specific scores across assessment intervals for Ms. B.

Table 2. Test Scores and Attachment Status for Case Study #2: Ms. B.

Case Study #2: Ms. B.	Pre-DBT	Post-DBT	Post-EMDR
PAI Diagnosis	Relational Problem NOS; BPD	None	Adjustment Disorder NOS
BASIS-32 Total	1.5*	.41	.43
BASIS-32 Relation to Self and Others	2.3*	1.0*	.57
DAPS PTS	96*	59	49
IASC Affect Dysregulation	77*	45	65
IASC Interpersonal Conflicts	77*	60	57
CAPI Abuse Potential	159	73	74
AAI	Earned Secure (no evidence of Unresolved Category)	Dismissive (no evidence of Unresolved Category)	Earned Secure (no evidence of Unresolved Category)

Note. BPD=Borderline Personality Disorder;

* = clinical level.

Participant #3: Ms. C

Presenting Complaints and History

Ms. C., a 58-year-old white female, had attended college and worked full-time with a yearly income of \$20,000 to \$30,000. She had adult children, was separated from her husband, and was not disabled or homeless. Ms. C. initiated therapy due to conflict in her relationships with her husband, adult children, and siblings; difficulties with identifying and communicating emotions; and low self-esteem. She reported a history of suicide attempts, and mood instability and depression that were currently treated by medications. Ms. C's diagnoses determined by her psychiatrist at the beginning of treatment were Bipolar I Disorder, depressed, mild, and Posttraumatic Stress Disorder.

Ms. C. reported verbal and physical abuse by her father and emotional neglect by both parents. She stated that she experienced ongoing bullying by her siblings, and that she was sexually abused by one of her brothers and a brother-in-law while she was growing up. Ms. C. reported two incidents of sexual assault as an adult, one of which included serious physical violence. She stated that a former boyfriend was physically violent with her and that her current husband was verbally and physically abusive. Her losses included her father's frequent absences due to his job as a salesman, her mother's three

absences due to severe “nervous breakdowns,” three grandparents’ deaths, and her father’s and her brother’s deaths when she was an adolescent.

Assessment and Course of Treatment

Prior to beginning the DBT skills training program, Ms. C. met criteria for Major Depressive Disorder, Generalized Anxiety Disorder, and Paranoid Personality Disorder on the PAI. She scored in the clinical range on all measures except for the DAPS PTS, and was categorized as Dismissive in attachment status with an Unresolved designation related to loss or abuse from parents on the AAI.

During the twelve months of DBT skills training, Ms. C. focused on decreasing the use of her main targeted behaviors of either arguing and fighting with her husband and children or avoiding conflict in her relationships; increasing effective skills’ usage especially in family relationships; and regulating her emotions. At post-DBT assessment, Ms. C. met criteria for Major Depressive Disorder, Generalized Anxiety Disorder, and Dysthymia according to the PAI. She showed improvement on the BASIS-32 Total, the BASIS-32 Relationship to Self and Others Subscale, IASC Affect Dysregulation and Interpersonal Conflicts subscales, and the CAPI Abuse Potential, although she remained in the clinical range on all measures with the exception of the IASC Interpersonal Conflicts subscale. However, Ms. C. worsened on the DAPS PTS, and maintained a Dismissive and Unresolved status according to the AAI.

During the preparation stage of the EMDR protocol, her therapist assisted her in linking present-day behaviors and triggers with negative cognitions or core beliefs related to past traumatic events. Ms. C.’s primary negative cognitions were: (a) I don’t matter/There is something wrong with me/I am a horrible person, (b) There is something wrong with me because my body responded to physical stimulation during sexual abuse, and (c) I am stupid/I should have known better/I should have stopped the abuse/I should have told someone about the abuse.

Ms. C. developed insight into the connection between her negative cognitions and specific past traumatic events such as physical abuse by her father, physical violence by a former boyfriend, bullying by her siblings, sexual assaults by her brother and brother-in-law, and two sexual assaults by strangers. Her therapist employed protocols to help Ms. C. develop a Safe Place and the internal resources needed to proceed with EMDR.

Throughout the 18 EMDR sessions, Ms. C. was able to process traumatic memories and the associated negative cognitions, affect, and sensations to

achieve distress levels between zero and one (on a 0-10 scale where zero is no distress), as well as develop and strengthen alternate positive cognitions to six or seven (on a 1-7 scale where seven is the strongest positive belief) such as: (a) I matter/What I say matters/I'm OK/I can make mistakes and laugh at myself, (b) The way my body responded was normal, and (c) I was too young to know what to do/I had good reasons not to tell my parents/I am only responsible for my own feelings, thoughts and actions. She was able to desensitize present-day triggers to past traumas as well as install future adaptive behavior templates.

Table 3. Test Scores and Attachment Status for Case Study #3: Ms. C.

Participant #3: Ms. C.	Pre-DBT	Post-DBT	Post-EMDR
PAI Diagnosis	MDD; GAD; PPD	MDD; GAD; Dysthymia	MDD; Dysthymia
BASIS-32 Total	2*	1.43*	.87
BASIS-32 Relation to Self and Others	2.9*	2.6*	1.43*
DAPS PTS	58	61* (<i>borderline clinical</i>)	47
IASC Affect Dysregulation	100*	86*	79*
IASC Interpersonal Conflicts	100*	51	46
CAPI Abuse Potential	348*	268*	216* (<i>borderline clinical</i>)
AAI	Dismissive/ Unresolved	Dismissive/ Unresolved	Earned Secure (no evidence of Unresolved Category)

Note. MDD=Major Depressive Disorder; GAD=Generalized Anxiety Disorder; PPD=Paranoid Personality Disorder.

* = clinical level.

At post-EMDR assessment, Ms. C no longer qualified for the diagnosis of Generalized Anxiety Disorder. Her Basis-32 Total score improved from the clinical range and her DAPS score decreased from the borderline clinical range to within normal limits. Her Basis-32 Relationship to Self and Others, IASC Affect Dysregulation, and CAPI Abuse Potential scores continued to improve but remained in the clinical to borderline clinical ranges. On the AAI, Ms. C.'s attachment status moved from Dismissive/Unresolved to Earned Secure with no evidence of Unresolved category related to loss or abuse by parents. Her diary cards showed continued improvement in emotion regulation and skills' usage and she reported to her therapist that because her self-esteem

was stronger and she no longer believed that her feelings were “wrong” or “bad” or that she deserved to be treated “badly” in relationships (e.g., verbal abuse or being taken advantage of), she was setting and following through with healthier limits in her family relationships and was enjoying a stronger sense of personal competence and self-confidence. See Table 3 for specific scores across assessment intervals for Ms. C.

Conclusion

The case study series in this chapter illustrates how phase-based trauma treatment integrating DBT and EMDR may effect significant positive change with adults who have complex case presentations of psychiatric diagnoses and/or substance abuse; histories of multiple traumas such as child abuse, witnessing domestic violence during childhood, sexual assault, and/or intimate partner violence; and significant present-day stressors. Results from five standardized measures, AAI interviews, and client self-reports showed significant overall improvement in regulating emotions and behavior, moving toward a healthier and more secure attachment status, decreasing psychiatric symptomatology and potential for continuing cycle of violence with partners or children, and resolving significant present-day stressors among these three cases.

During the first phase of treatment, DBT skills training, clients reduced symptoms that interfered with functionality; stabilized present-day stressors; and increased cognitive, emotional and behavioral regulation. Once more emotionally regulated, the clients identified present-day triggers for their problematic behavior patterns, associated those patterns with underlying negative cognitions/core beliefs, and connected the negative beliefs with past traumatic events. The clients employed DBT skills throughout the EMDR therapy to tolerate emotional intensity, focus on traumatic material during sessions, and maintain stability in their lives outside of therapy. Throughout EMDR, the clients were able to access and process traumatic memories with associated negative cognitions, emotions, and sensations, as well as acquire more adaptive beliefs, emotions, and behavior.

The positive clinical outcomes noted in these cases merits further study. More specifically, randomized, controlled studies evaluating the efficacy of phase-based trauma treatment (DBT/EMDR) with this complex population of adults are warranted. Studies that include males and more ethnically diverse groups of clients are also needed.

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