Social Work Trauma Interventions: Dialectical Behavioral Therapy

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Abstract

According to Lynne Weilart (2013), in her article on the reasons why people seek out therapy, trauma is the number one reason people attend counseling. Many different trauma-informed approaches are designed specifically to address the consequences of trauma and to facilitate healing. Some of these approaches are as follows: Cognitive Behavioral Therapy (CBT); Dialectical Behavioral Therapy (DBT); Mentalization Based Therapy (MBT); Trauma Systems Therapy (TST); Trauma Assessment Pathway (TAP); and Attachment, Self-Regulation, and Competency (ARC) (de Arellano, Danielson, Ko, & Sprauge, 2008). The effectiveness of each trauma intervention will be examined. DBT is one of these trauma interventions that is growing rapidly in its popularity, as it is now recognized as a "gold standard" psychological treatment (Linehan, 2017). The biopsychosocial-spiritual-environmental social work model will be used to display the impacts of DBT. The skills taught through the DBT program impact each diagnosis and population differently. Evidence from past research will be used through an extensive literature review. For the sake of clarity, the titles "clinical social worker" and "therapist" will be used interchangeably for ease of wording throughout the thesis. This persuasive thesis will encourage clinical social workers in the field of mental health to use this specific trauma intervention more often.

Social Work Trauma Interventions: Dialectical Behavioral Therapy

Trauma is a word that is often overused in everyday language, but the key component of true trauma is that it refers to extreme stress that impacts a person's ability to cope. According to the American Psychological Association (2018), trauma is "an emotional response to a terrible event like an accident, rape, or natural disaster" where shock and denial are typical immediately afterwards, and many people have difficulty moving on with their lives (APA, 2018, para. 1). More specifically, psychological trauma is where the individual's subjective experiences are a threat of life, bodily integrity, or sanity (Pearlman & Saakvitne, 1995). The definition for trauma is quite ambiguous, as it includes both responses to specific events, such as an accident or a death, and responses to chronic or repetitive experiences, child abuse or serving in combat. It is important for social workers working with clients who have psychological trauma to remember that this definition of trauma does not allow for them to decide whether something is traumatic, as the experience of the survivor defines trauma.

Although there are many different interventions that focus on a trauma-based approach, this thesis will focus on the approach of DBT. This is because research has shown DBT to be effective in lessening the implications of non-suicidal self-injury, suicidal behavior, psychiatric hospitalization, treatment dropout, anger, substance abuse, and depression. Mentalization Based Therapy (MBT), Trauma Systems Therapy (TST), Trauma Assessment Pathways (TAP), Attachment/Self-Regulation/Competency (ARC), and Cognitive Behavioral Therapy (CBT) are examples of alternative trauma interventions that will be compared to DBT below. MBT focuses on a client's capacity for *mentalization*, "the capacity to think about the mental states of oneself and others as

separate from, yet potential causing actions" (Bateman & Fongay, 2004). This focuses on the deficits of the client, using transference, retaining mental closeness, and working with current mental states; DBT uses more of a strengths-based perspective and aids clients in working through their emotional states as well as their mental states. Trauma Systems Therapy (TST) is oftentimes used with children dealing with traumatic stress, and it is successful because it integrates individual interventions with services in the different environmental settings of the children: the home, school, and community. Children are assessed in their social contexts, given treatment plans that include families, and given a multidisciplinary team to work with along with multiple service systems. Much like DBT, clients working with TST are given tools to build emotion regulation and cognitive processing skills. Whereas DBT focuses more on the psychological environment of the client, TST looks at how factors in the social environment interact with a client's ability to recover from trauma (Saxe, Ellis, & Kaplow, 2007).

Another alternative treatment is the Trauma Assessment Pathway (TAP), which is similar to DBT, as it includes a variety of standardized assessment measures based on the needs of the clients, their families, and communities. The goals of TAP are to provide treatment center staff with knowledge and skills in these standardized assessments, to provide a treatment model that is unique to each client, and to provide guidelines to make decisions regarding trauma treatment ("Assessment-Based Treatment for Traumatized Children: Trauma Assessment Pathway [TAP]," n.d.). TAP, like DBT has an intense focus on the individualization of treatment plans, which allows the client to have freedom in their services. The last alternative trauma intervention compared is that of Attachment, Self-Regulation, and Competency (ARC). This is an intervention framework that

identifies three core domains that are relevant to future resiliency, and it offers a guiding structure for providers. In the attachment domain, caregiver affect management, attunement, and consistent response are included; the regulation domain consists of identification, modulation, and expression, and the competency domain consists of executive functions and self-development. Research suggests that ARC leads to reduction is PTSD and general mental health symptoms, as well as increased adaptive and social skills (Blaustein & Kinniburgh, 2017). It is evident with this information that, like DBT, ARC covers a wide variety of psychological aspects.

Studies show that DBT also improves both the social and global functioning of its clients (Linehan, 2017). In comparing DBT to CBT specifically, it is important to note that CBT has many solid techniques, such as skills training, homework assignments, behavioral rating scales, and behavioral analyses. However, DBT also incorporates tools in sessions such as the "devil's advocate" teaching, irreverence, and the use of metaphor to help clinical social workers to be able to blend acceptance and change that results in an overall rise in clients' life satisfaction (Linehan, 2017). DBT splits therapy sessions into four different skills that aid each client in dealing with their trauma: mindfulness, distress tolerance, emotion regulation, and interpersonal effectiveness. It would be to the benefit of clinical social workers to become more knowledgeable about DBT so that they can better educate and serve their co-therapists, clients, and communities on the effectiveness of these skills. Ultimately, it would be to the benefit of clinical social workers to incorporate this intervention method in practice techniques so that they may see clients thrive in their individual environmental settings.

DBT Overview

DBT brings together the intellectual side of the mind (such as thinking, reasoning, or remembering) and the emotional side of the mind to find a balance in one's thought processes (Arnold, T., 2008). The word *dialectical*, according to the Merriam-Webster dictionary (2018), is "a method of examining and discussing opposing ideas in order to find the truth." This term also deals with comparing facts with a view to resolve contradictions. DBT is an empirically supported treatment originally developed for chronically suicidal adults, but now it can be applied trans-diagnostically. These diagnoses include: depression, psychosis, eating disorders, substance use disorders, borderline personality disorder, and posttraumatic stress disorder (Ritschel, 2015). The populations studied in the literature below are as follows: women, children, adolescents, and veterans. Clinical social workers implement a therapy component by coinciding all five functions of treatment in working with each of these populations. The five goals of DBT are: to enhance clients' capabilities, improve clients' motivation, assure generalization to the clients' natural environment, structure the environment, and to enhance the therapists' capabilities and support their motivation. The therapy components that support these functions are respectively as follows: DBT skills training, individual psychotherapy, in-the-moment-coaching, case management, and a DBT consultation team. Incorporating all five of these components into therapy helps clients develop effective ways to navigate situations that arise in everyday life or to manage specific challenges (Linehan, 2017).

Marsha Linehan founded DBT in the late 1970s to focus CBT strategies on treating women with histories of multiple suicide attempts, suicidal ideation, and self-

injurious behaviors (Linehan, 2017). According to the database PsycInfo, there are an average of 8 published DBT articles per year from 1993-2000, 41 articles published per year from 2001-2010, and about 78 per year since 2011 (Linehan, 2017). This shows that there is always new research on this specific trauma intervention. The therapy itself has also progressed, as acceptance-based and validation strategies (mindfulness and distress tolerance) were added to the change-based strategies (emotion regulation and interpersonal effectiveness) of the current CBT strategies. These change-based strategies consist of: active, goal-oriented problem-solving approaches, engagement in collaborative empiricism between therapist and client, identify, evaluate, modify, and replace distorted cognitions with more accurate and adaptive cognitions, and other "classic" behavioral techniques such as exposure to feared stimuli (Gaudiano, 2013). The additions that Linehan made to turn CBT into DBT were made because it was found that many clients in CBT programs did not prefer the constant focus on change, as they perceived it as being invalidating (Matusiewicz, Hopwood, Banducci, & Lejuez, 2010). The motive behind Linehan's additions was to develop strategies that would help clients make a "life worth living." Linehan added acceptance-based interventions that allowed clients to realize that their thoughts, feelings, and behaviors were normal. This proved that they had sound judgment and they were capable of learning how and when to trust themselves. Adding acceptance to change seems to be contradictory at face value, but it aids clients in balancing their actions, feelings, and thoughts in daily life (Linehan, 2017).

DBT has various effective components, such as the prioritization of treatment targets or the various stages of treatment. With DBT, individualized strategies and procedures, as well as various aspects of treatment, can be included or withdrawn as

needed based on severity, risk, disability, pervasiveness, and complexity of trauma experienced by the client to guide the stages of treatment more effectively (Foote & Van Orden, 2016). DBT skills are taught through a curriculum-based model, so they are more structured around the curriculum than the needs of a single client during a session, as is similar with other therapy models. Clients who receive DBT typically have multiple problems that require treatment, in which there is a hierarchy of treatment targets. The first includes any life-threatening behaviors; the second includes any therapy-interfering behaviors; the third includes quality of life behaviors; and the fourth includes skills acquisition. DBT is a staged treatment where behavioral and safety issues are addressed in the aforementioned first stage, and trauma work is handled in the second stage (Foote & Van Orden, 2016).

In an interview with a client who has gone through a DBT program that was specifically geared towards adolescents with self-injurious and suicidal tendencies, it was learned that both the client and the clinical social worker must be extremely dedicated to successfully complete this strenuous therapy program. Clinical social workers both counsel and validate the client through specialized cognitive techniques called *mindfulness techniques*. Mindfulness is where a client becomes aware of thoughts, feelings, behaviors, and behavioral urges to take charge of his or her own life to bring about positive change (Arnold, 2008). These skills bring together the emotional parts of the mind with the logical side of the mind. Each of these parts of the mind have strengths and weaknesses but come together to produce a balanced *wise mind*; this is the ideal state of mind to strive for, as it allows for an awareness of both feelings and practical goals. Having a balanced *wise mind* helps clients become aware of their thought processes and

be able to work through them in a practical way. An interviewed client discussed this practical thought process by saying, "It's cleaning out the attic so you can turn on the light" (Summers, A., personal interview, January 25, 2018).

DBT is an intense form of therapy that requires a lot of effort and commitment for both the client and the clinical social worker, so social workers often have a goal of having positive engagements with their clients. This is the process through which clients become active and involved in their treatment (Jacobson, 2013). In a study by Jacobson (2013), five social workers discussed their engagements processes with involuntary clients with a strong emphasis on giving their clients choice and control over the treatment. Clinical social workers who implemented approaches that strengthened relationships and motivation were cited as fostering better engagement with involuntary clients. An example of implementing choice and control in a DBT group would be to create the rules of the DBT group with the group so that they feel as if they have more control of their surroundings. Allowing clients to set their own short-term and long-term goals is another way to implement this choice and control to strengthen the therapeutic relationship between the involuntary client and the clinical social worker. These tools are key because of the high dropout rates in outpatient DBT, markedly as high as 24% to 58% (Landes S, Chalker, S., & Comtois, K., 2016), oftentimes resulted in clients being unresponsive in treatment. Motivating both voluntary and involuntary clients towards a goal of healing is particularly important so that skills such as mindfulness techniques and distress tolerance can be a more effective intervention when working with traumatized clients.

Ethics and Values

The *National Association of Social Workers (NASW) Code of Ethics* (2008) reflects the core values and principles of the social work profession and sets up a set of ethical standards that can be used to guide practice. One of these core values is that social workers are to respect the inherent dignity and worth of the person by promoting clients' socially responsible self-determination. Because of this, clients become able to identify and clarify their goals. Clinical social workers, in their professional judgement, then work to enhance clients' ability and opportunity to change. With this core value of respecting a client's autonomy, dignity, and worth as a person, each case is handled differently with individualized case plans. There are many different variations of the DBT program because of this. The social work value of the importance of human relationships can be integrated within these different variations. Clinical social workers would then have the freedom to take part in a purposeful effort to promote, restore, maintain, and enhance the well-being of individuals, families, social groups, organizations, and communities (National Association of Social Workers, 2008).

Biopsychosocial-Spiritual-Environmental Model

In looking at trauma-related interventions within the social work field, it is important for assessments to be broad enough to incorporate each of these following areas: biological (medical), psychological (mental), social, spiritual, and environmental. Interventions from each of these areas may be used, as they are all intertwined. This model is a science-based metatheoretical perspective that integrates a full range of each of these areas. Using this model helps clinical social workers better understand human nature, including the problems and limits that people encounter while living their lives.

Biological Aspect of the Model

Biopsychology, a branch of psychology that analyzes how the brain, neurotransmitters, and other aspects of the composition of the human body influence behaviors, thoughts, and feelings, is often used by clinical social workers when using this aspect of the model (Cherry & Gans, 2017). Social workers are able to look at how some of these biological processes interact with emotions, cognitions, and other mental processes: "A key insight to take away from a discussion of medicine is that your physical health is the foundation upon which your mental health and happiness rests" (Dombeck, 2018). It is important to evaluate the biological aspect of the human composition when assessing mental health needs. With this information, it is important to note that some people are born with a susceptibility to be less resilient, thus making them more biologically vulnerable to depression and other trauma-related issues (Franklin, 2012). Resilience is a defense mechanism that enables people to remain stable and support healthy levels of physical and psychological functioning in the fact of disruption or chaos (Davydow, Stewart, Ritchie, & Chaudieu, 2010). Resilience can also be defined as being an adaptive characteristic that enables a person to cope with and recover from adversity (Iacoviello et al., 2014). When a client undergoes stress and trauma, there are typically two extreme responses: developing psychiatric disorders or exhibiting resilience. A study by Franklin et. al (2012) showed that multiple neurochemical and neuroanatomical pathways within the brain react differently to stressors such as trauma in resilient and susceptible individuals.

The main concepts of the biological model would be items such as age, weight, height, ethnicity, and health levels. Certain health issues could affect chemical levels in the brain, explaining the chemical imbalances in mental health diagnoses such as depression or anxiety. A person's chronic health issues could also add to the level of trauma that a person experiences. Having a chronic illness, such as cancer, puts individuals at greater than threefold risk for psychiatric disorders, as well as considerable risk for social adjustment problems (Cadman, Boyle, Szatmari, Offord, 1987). Adversely, depression can take on physical symptoms at times, such as slowed speech or a lessened appetite. Staying physically active or taking medications can aid in dealing with certain aspects of trauma, but there are different degrees of trauma that cannot be handled by means of biological or medical interventions.

Psychological Aspect of the Model

The psychological aspect of the model places an emphasis on relieving psychological distress and reducing symptomology in the lives of clients. This is done by a therapist utilizing a range of evidence-based therapies to build strengths while treating the issues at hand (Melchert, 2011). One of the main evidence-based therapies that is used in the psychological aspect of the model is CBT. Using these techniques is beneficial dealing with the implementation of mindfulness skills through DBT. Multiple different psychological theories can be used to evaluate trauma in a person's life such as: learning theory, psychodynamic theory, humanistic theory, (personality) trait theory, and a range of theories that are based on human development.

Learning theory. The learning theory comes from the work of Ivan Pavlov, and its key insight is that most behavior is learned. A main function of this theory is when

reinforcements and punishments such as classical conditioning are applied, such as the ones in the DBT framework. Classical conditioning happens when one associates a neutral stimulus with a stimulus that has been associated with a certain level of meaning. Analyzing this process helps clinical social workers to better understand and predict how people learn. A main aspect of this theory that ties into DBT is that clinical social workers can look at patterns of mental events in a client, such as thoughts and feelings, and are then able to teach their clients new ways of thinking, thus using classical conditioning in the cognitive form (Dombeck, 2018).

Psychodynamic theory. Sigmund Freud played a key role in the developing of the psychodynamic theories. These theories consider both the irrational/impulsive and the rational sides of the mind. The mindfulness techniques in DBT stem from this theory, as they both deal with the emotional and rational sides of the mind. It is important to note that these techniques are designed to help a client become more conscious of unconscious habits, patterns and preferences that have been established during the preliminary stages of one's life. This simply helps clinical social workers provide their clients with insight and enable clients to become free to challenge their own thought processes (Dombeck, 2018).

Humanistic theory. The humanistic approach is a blend between psychodynamic and behaviorist learning approaches that focuses on the autonomy of clients. S*elf-actualization* deals with the self-expression that drives individuals to do what they desire in life; this helps the client connect with his or her innermost desires and feelings (Olson, 2013). This ties into the DBT emotional regulation interventions. A sense of selfishness is encouraged with this view, but it does so in a way that assists

clients in being happy through setting limits and taking responsibility for their own actions.

Personality trait theory. Another theory that focuses on humanity would be that of the personality trait theory, as it describes a set of traits that differentiate people from those around them. These traits include: extraversion, agreeableness, conscientiousness, emotional stability, and openness to experience. Clinical social workers using DBT with this theory help clients take their personality styles into account when making important decisions (Dombeck, 2018). Using this theory enables clinical social workers to exercise the social work value of honoring the dignity and worth of a person.

Developmental theory. Developmental theories consider the lives of people from birth to death to evaluate the processes of change. With this theory, it is important for clinical social workers to keep in mind that everyone develops at different rates. In the DBT program, each client is then given their own individualized plan. Oftentimes developmental issues come with certain personality disorders, varying in emotional coping and maturity levels, or anger and emotional control problems (Scott, Mihalopoulos, Erskine, Roberts, & Rahman, 2016). A goal of clinical social workers using DBT within this theory would be to minimize cumulative damage caused by developmental delays (Dombeck, 2018). According to Scott et. Al (2016), the best way a clinical social worker could minimize these damages would be to address the mental health problems of the parents and improving parenting skills, as this has the greatest potential to reduce developmental disorders in children.

Social Aspect of the Model

Humans interact with each other daily, so the encouragement of healthy human interaction is an important aspect of DBT; this can be seen in the core skills module of interpersonal effectiveness, a main component of DBT. This aspect of therapy teaches assertiveness, interpersonal skills, and conflict resolution. In treating those with borderline personality disorder, clinical social workers often deal with the issue of interpersonal dysregulation indicated by chaotic relationships and fears of abandonment (Shelton, Kesten, Zhang, & Trestman, 2012). Clients are encouraged to use the two key components of interpersonal effectiveness, the ability to say no and the ability to ask for things when appropriate, to interact in a more deliberate and thoughtful manner instead of acting and reacting impulsively. There are three levels of effectiveness: objective, relationship, and self-respect effectiveness. Each area of effectiveness is important and must be prioritized for the highest level of success in the lives of the clients. An example of a specific DBT tool that is used in the objective effectiveness module is the acronym of DEAR MAN, and the skills are as follows: Describe the situation without judgment, Express feelings, Asser wishes, Reinforce why the desired outcome is desirable, Mindful (be mindful and present in the moment), Appear confident, and Negotiate and give in order to get with understanding of the other party's needs and feelings (Bray, 2013). A skill taught on the topic of relationship effectiveness uses the acronym GIVE: Gentle, approach the other party in a gentle way, avoiding judgments; Interested, act interested by listening and not interrupting; Validate and acknowledge the other person's wishes, feelings, and opinions; and Easy, adopt an easy manner by smiling (Bray, 2013). The last skill taught in this module on the topic of self-respect uses the acronym FAST: Fair, be

fair to yourself and the other person to avoid resentment; Apologize less and take responsibility when appropriate; Stick to your values and don't compromise your integrity; Truthful, be truthful and avoid exaggerating (Bray, 2013). These interpersonal skills open possibilities for positive outcomes in the relationships of clients when used effectively, as they help clients convey their needs with integrity and consideration of the other's feelings. When clinical social workers are able to integrate these interpersonal skills into sessions, they are then able to better exercise the social work value of the importance of human relationships.

Also, on the topic of social implications in the field of mental health, it can be noted that depression and trauma are psychological issues that hold social implications such as social withdrawal. Today's culture has many prominent negative social contexts, such as broken family structures and the overuse of social media and advertising. This impacts how a client deals with the trauma they have undergone and their levels of resilience and adaptability. These factors are not always the cause of trauma, but they are a casualty of the trauma in a multi-generational system. The social implications of broken family systems imply that people depend on each other to gain a sense of safety, social support and belonging. The humanistic view sees that individual problems oftentimes stem from unhealthy boundaries within the family system, so it would benefit clinical social workers to utilize the DBT tools of family sessions. These unhealthy boundaries can serve as good indicators that the family and social systems in the life of a client are not functioning properly (Dombeck, 2018).

Spiritual Aspect of the Model

A core competency in social work practice among those in the North American Association of Christian Social Workers (NACSW) is to integrate faith and practice. An interview conducted with the DBT client, A. Summers, showed that working on mindfulness skills helped this client grow in her faith. Her therapist was a Christian, but the services were not provided through a faith-based organization. The therapist in this setting was able to integrate faith into practice and the client expressed that her therapist held to extremely strict boundaries, putting the clinical aspect of the DBT program as the top priority. The client's spiritual side was touched on only when the client asked directed questions to the therapist, and this balance established trust in the counselor-client relationship (Summers, A, personal contact, January 25th, 2018). The NACSW Code of Ethics also incorporates the importance of human relationships and responsibilities, stating that humans have been created to be social beings, and that all relationships are interconnected. The DBT program's incorporation of both acceptance and change-based strategies allows for clients to be interdependent with each other and with their social and physical environments. In looking at human relationships from a Christian perspective, the NACSW states in its Statement of Faith and Practice that "Jesus Christ is Lord over all areas of life, including social, economic, and political systems" (Keith-Lucas, 1980, para. 10).

In a study by David C. Wang and Siang-Yang Tan (2016) on clinical applications of DBT from a Christian perspective, it was found that DBT tools can be applied readily in treatment with little or no interaction or tension raised in relation to matters of faith. Wang and Tan point out that the DBT tool of acceptance lines up with the Christian faith,

as this is a common theme within the faith and with Jesus Christ himself. Acceptance in DBT and in the Christian faith also incorporates aspects of love and redemption, as God declares individuals as righteous just as they are, even while they were still sinners (cf. Romans 5:8) and invites them to be set apart for His glory (cf. Ephesians 2:10). The DBT concept of wise mind can also be understood from a Christian perspective, as both rationality (cf. Isaiah 1:18-20, 1 Corinthians 13:11) and emotion (cf. Ecclesiastes 3:4-6, Mark 14:32-34, Proverbs 17:22) are in the human constitution. When a Christian finds his identity in Christ, he can be free of the internal conflict between the rational and emotional aspect of humanity by becoming one with Christ. Practicing non-judgment consists of clients rephrasing statements of judgment by encouraging clients to use "I" statements instead of "you" statements; this allows clients to distinguish the facts and judgements of their situations thoughtfully and accurately, which can support coping behaviors that focus on healthy problem-solving. Wang and Tan have found that when Christian clients use non-judgement in their thought processes, they are able to have breakthroughs where they "bear witness to the comparison that God has for them even as he sees their suffering" (Wang & Tan, 2013, p. 73). The last application from DBT to the Christian faith can be seen in the context of mindfulness skills, where Christians are called to take every thought captive (cf. 2 Corinthians 10:5) and back up their feelings and actions with biblical truth. Incorporating these Christian foundations into DBT can allow Christian clients to focus on the present moment (cf. Ecclesiastes 5:18-20, Isaiah 43:18-19, Matthew 6:34, James 4:14) and anticipate the future with hope in Christ (cf. Jeremiah 29:11, 1 Peter 1:3-4, 1 Thessalonians 5:1-11).

Environmental Aspect of the Model

When clinical social workers focus on this model, it is understood that they cannot fully understand clients when the client is studied in isolation; clients must be evaluated within the network of relationships that are already in place (Dombeck, 2018). This ties in the trauma-related issue to clients' social environment. Social workers then draw information and make educated assumptions from these environmental implications. DBT skills use two primary areas of intervention in the environmental aspect of the model: acceptance and change. The area of acceptance includes topics such as validation, reciprocal communication, and environmental intervention on behalf of the client. The area of change includes problem solving, irreverence, and consultation to the clients about how they can change their own environment. In an interview conducted with a DBT client, it was said that there was a focus on the social environment of the client. In this specific setting, the therapist used the client's home life to tie in other trauma-related issues to the counseling sessions. The therapist was then able to see that family counseling would not have been beneficial for this client specifically. On the topic of this client's environmental setting, the interviewed client stated, "Feeling safe in my environmental setting was important so that I could feel safe in my own mind as well" (Summers, A., personal communication, January 25, 2018).

Literature Review

Borderline Personality Disorder (BPD)

DBT techniques can be used effectively with those diagnosed with BPD because it is primarily grounded in behavior theory (the biosocial theory of BPD). The biosocial theory exemplifies the difficulty of regulating emotion being the driving force of BPD.

Both environmental and biological factors impact emotional sensitivity and dysregulation levels. DBT has had significant impact on those diagnosed with BPD, and it has significantly decreased suicide risks, substance abuse, self-injurious behaviors, and levels of dissociation as is shown in Linehan's study (Harned et al, 2010).

Children and adolescents. Little is known about the internal structure of BPD in the younger populations, as was found in the study by Michonski et. al (2013) from the Dialectical Behavior Therapy Center of Seattle. This study evaluated individual BPD criterion to see the effectiveness that DBT may have on children and adolescents. The five areas studied are as follows: uncontrolled anger, suicidal behaviors, impulsivity, abandonment feats, and unstable relationships (Michonski et al, 2013). With this population, emotional regulation and reactivity symptoms were easier to diagnose and observe than suicidal behaviors and abandonment fears. It was found that there were differences among genders with this diagnosis, as more females struggled with both aggressive and nonaggressive forms of impulsive behaviors. This could be related to an emphasis on relational styles based on emotional connection in females, leading to the conclusion that DBT may be more beneficial for females than for males at this specific developmental stage (Michonski et al, 2013).

Women. DBT was initially developed to treat chronically suicidal women diagnosed with borderline personality disorder (BPD), which shows the results of a dysfunctional emotion regulation system associated with instability of thoughts, emotions, behaviors, relationships, and self-image (Linehan, 2017). With this population, DBT has been proven to reduce hospital admissions and reduce treatment dropout rates in severely impaired populations (Harned et al., 2010). It also produces specific

improvements in suicidal ideation, depression, and hopelessness, all of which will be discussed in a later section. Women with BPD are the most researched population group when it comes to the trauma intervention of DBT.

Veterans. According to the study by Scheiderer et al (2017), participating in a dual DBT and prolonged exposure (PE) program has been shown to reduce symptoms and improve the overall quality of life for a veteran with posttraumatic stress disorder (PTSD) and BPD. Both PTSD and BPD associated with difficulties in emotion regulation and can at times feature dissociative symptoms (Scheiderer et al, 2017). The main symptoms of BPD in veterans are severe depression, anger, excessive physical tension, overwhelming anxiety, disassociation, and numbing. PE is a type of cognitive behavioral therapy (CBT) that focuses on emotional processing and exposure-based treatments (Peterson, Foa, Riggs, 2011). Emotional processing theory relates the fear that a veteran feels to the details of that feared stimulus and works towards changing the meaning of that fear. PE helps clients successfully process traumatic memories to reduce the effects of trauma. Alongside the rigorous DBT regimen, the veterans in this study participated in nine to twelve 90-minute weekly or biweekly sessions that focused on gathering reactions to different trauma stimuli, breathing retraining, and psychoeducation regarding exposure. The study consisted of one client attending 24 months of outpatient psychotherapy, including 76 individual therapy and 65 skills group appointments, as well as a two-month course of PE (11 sessions). The trauma interventions are used concurrently because DBT alone does not directly address the traumatic experiences that veterans have gone through. Using both trauma interventions stabilizes the risk of self-

injurious behaviors and establishes emotional regulation and distress tolerance skills when one deals with trauma memories (Scheiderer et al, 2017).

Oftentimes veterans have levels of dissociation to deal with their trauma, leading to rebellious behaviors, such as engaging in substance abuse or self-injurious behaviors (Scheiderer et al, 2017). This can be monitored in DBT with the daily diary cards or through behavioral chain analyses to focus on mindfulness skills; in PE, engaging in these behaviors is viewed as an avoidance strategy, indicating noncompliance with the expectation that a client would actively work to recover from exposures. As was previously discussed, each exposure situation is assessed based on severity, so the life-threatening behaviors were addressed first through psychiatric treatment. Additionally, therapy-interfering behaviors were addressed and were then implemented with more skillful distress tolerance behaviors. Using the technique of imaginal exposure through role-playing was an effective trauma intervention in this study because the client was able to utilize interpersonal effectiveness skills. In looking through the lens of Biopsychosocial-Spiritual-Environmental social work model, it can be noted that the environmental factor of the trauma that a veteran goes through impacts the complexity of the presented BPD. In all, this study provides further support for the effectiveness of the dual DBT and PE programs within the context of treating veterans.

Depression, Suicide, and Self-Harm

Children. Mentalization-based theory (MBT) is often associated with DBT, as it relates to the attachment theories in the developmental process of a human dealing with trauma (Bateman & Fongay, 2004). The main goal of MBT is for clients to retain mental closeness to enhance mentalizing capacities. Specific therapeutic interventions of MBT

include “representing accurately the current or immediately past feeling state of the patient and its accompanying internal representations and by strictly and systematically avoiding the temptation to enter conversation about matters not directly linked to the patient’s beliefs, wishes, feelings, and so forth” (Bateman & Fonagy, 2004, p. 44). In dealing with depression, suicide, and self-injurious behaviors in preadolescent children (6-13 years of age), an adaptation to the normal DBT program now incorporates child-friendly activities and materials as well as involving caregivers in the treatment processes. Clinical social workers committed to teaching the mindfulness techniques in a way that makes sense to the child ensure the usage of developmentally appropriate language and materials. Many of the assigned tasks that are normally required in a DBT program may be altered for children to form a fun atmosphere for skills training. Using technology, toys, games, and other play therapy techniques would be beneficial tools for social workers to use, as is exemplified in the study by Perepletchikova and Goodman (2014). Role-playing is a beneficial technique that can be incorporated into DBT techniques with children.

Using MBT with children during therapy sessions helps children be able to reflect on their own thought processes (noting on physiological and affective cues), provides them with opportunities to play (which enhances impulse control, delayed gratification, and affect tolerance), and works on transference issues that often come with severe emotional disorders. The client-counselor relationship formed during play therapy oftentimes creates a sense of security for the child; this helps the child be able to properly associate emotions in the real world. Although there are many similarities in the thought processes behind both DBT and MBT, DBT was shown to be more applicable in real

world situations for the children, while MBT was only shown to be beneficial for play situations. Irreverence is used with DBT techniques when the clinical social worker uses provocative responses to help clients re-balance in certain situations; clinical social workers using MBT would be confrontational in their responses, which negatively impacts an already fragile child. The main objective of each of these approaches is for clinical social workers to assist their young clients in reaching a certain level of emotional regulation and understanding. Young children can respond to the stimuli given in therapy sessions through these two approaches.

Adolescents. In the study conducted by Geddes et al. (2013), a group of six adolescents (female; aged 14.6 to 15.7 years), who participated in acts of non-suicidal self-injury and suicidal ideation, received 26 weeks of a highly structured DBT program with a parent. The components of the DBT program in this specific study included individual psychotherapy sessions twice a week, weekly family skills-based training, telephone consultation between sessions, and weekly team consultation-supervision meetings. The six participants were evaluated as follow-up study to find a link between childhood trauma and maladaptive emotion regulation strategies. Levels of suicidal ideation, emotional regulation, and trauma symptoms were assessed throughout the program. It was found that adolescents engaged in less self-destructive behaviors and showed less trauma-based symptoms after a three-month period of participation in the DBT program. Upon completion of the program, the participants reported improved emotional regulation, and four of the six adolescents no longer needed any supplemental mental health services (Geddes et al, 2013). With this specific population, it was found that clinical social workers needed to specifically target these negative thought processes

through emotional regulation interventions dealing with impulse control and goal-directed behaviors.

In this study (Geddes et al, 2013), it was concluded that outpatient therapy was necessary to minimize the influence of confounding environmental factors on treatment outcome. Assessing the efficacy of this intense DBT program in an outpatient community-based setting was the aim of this study. Five of the six participants stopped self-injurious behaviors over the course of treatment. The participants were able to report significantly large reductions in anxiety, depression, and posttraumatic stress symptoms, as well as a substantial reduction in anger symptoms. On the topic of emotional regulation, the adolescents were able to note a reduction in their fear of emotions and growth in capability to manage their strong emotions. The elevated level of dropout (only one of the six participants remained in therapy following the end of the study) confirms that this program requires diligence on both the clinical social worker and the client (Geddes et al, 2013). A behavioral chain analysis is a common tool used within the DBT program that could be used with this population to assist clients in understanding the reasons behind their actions, as well as helping them to take responsibility for these actions.

Women. In a study focusing on suicidal and self-injuring women (Harned, Korslund, & Linehan, 2014), the clients participated in a pilot study that dealt with both DBT and DBT+PE techniques. The main prognostic variables of the participants were: (1) number of suicide attempts in the last year, (2) number of non-suicidal self-injurious (NSSI) episodes in the last year, (3) PTSD severity, (4) disassociation severity, and (5) current use of medication. The participants were 18-60-year-old women with recent and

recurrent intentional self-injury episodes. Those participants who participated solely in DBT treatment had weekly individual psychotherapy, group skills training once a week, phone consultation, and weekly therapist consultation sessions; those who added the PE component to the DBT techniques were able to do so only because they had achieved a certain level of control over the higher priority issues such as suicidal ideation. There were 17 participants that completed therapy to the point of analysis with DBT+PE and 9 participants in just the DBT program that completed therapy to the point of analysis. Diagnostic interviews, trauma histories, treatment feasibility/acceptability/safety were all assessed as well (Harned et al, 2014).

Both treatments showed large improvements in PTSD severity, but those who participated in the DBT+PE branch were 1.3 times more likely to report reliable and clinically significant improvement in PTSD (80% vs. 60%) and 2 times more likely to achieve diagnostic remission (80% to 40%) than those who participated solely in the DBT program (Harned et al, 2014). With this knowledge, it can be inferred that DBT intervention techniques with this specific population group could be used as a supplemental trauma intervention or in a stand-alone manner depending on the severity of the diagnosis. According to the evidences provided in this study, the levels of PTSD severity may have reduced due to the DBT skills that were put into place that managed anxiety and trauma-related cognitions. This is consistent with research showing that changes in PTSD symptoms account for 80% of changes in depression during PE (Aderka et al, 2013). There are many correlations between depressive symptoms and those relating to PTSD.

Future Study

Dialectical Behavioral Therapy is a highly effective trauma intervention tool that would benefit clinical social workers to utilize in their counseling practices more often. Given the aforementioned information, DBT assists clients with their interpersonal effectiveness, emotional regulation, distress tolerance, and mindfulness skills. These are all coping skills that, when implemented effectively, can reduce the effects and symptoms of trauma in the life of clients (Tull & Gans, 2017). Some suggestions for future study would be as follows:

Continuing Education

According to the NASW Code of Ethics, social workers can also function as educators, field instructors, and trainers, but can only do so within their areas of knowledge and competence. Providing instruction based on the most current information and knowledge available in the profession is also important. Section 3.08 of the NASW Code of Ethics titled *Continuing Education and Staff Development* states, "Continuing education and staff development should address current knowledge and emerging developments related to social work practice and ethics" (National Association of Social Workers, 2008). Continuing education is an important aspect for those in the social work profession and those in their agencies on how to deal with current issues in a relevant way. Since DBT is a relatively new trauma intervention, those who are aware of its benefits have the responsibility to educate others on its benefits. Even those clinicians who do not primarily focus on behavioral or cognitive-behavioral theoretical orientation may still incorporate DBT skills training into their clinical work to instill in clients a motivation for change. Clinical social workers who are trained in DBT can impart their

knowledge on their colleagues by sharing DBT training manuals and corresponding DBT skills training handouts and worksheets booklets so that more clinicians can assist their clients in building competence and remediating skills deficits.

Building DBT Teams

An important facet of the DBT program is the full support of the community. DBT consultation teams usually discuss treatment responses, note occurrences of therapy-interfering behaviors, and modify the distress tolerance plans that have been put into place for each individual client. Collaborating with members within the community by providing a workshop for healthcare providers, emergency staff, and even inpatient psychiatric providers is an aspect of this building process that ensures a continuum of care across the community. When a team is formed, the responsibility of the twenty-four-hour-a-day phone consultation could be split between qualified individuals in various positions, much like a suicide prevention hotline. This would also open doors for those in the community to make full use of supervision and consultation, a prominent social work practice behavior under the core competency of professional identity. Doing this would promote fidelity and effective flexibility within the DBT team and the community. This support will also help prevent burnout, a common side effect among clinicians working with high-risk patients, in clinical social workers. When consult and supervision is utilized concerning the treatment plans of clients, within the boundaries of confidentiality, clinical social workers are better able to see patterns concerning specific treatment goals and therapy-interfering behaviors.

Building Resilience Within Communities

The risk of developing PTSD after a traumatic event is 9%, according to a high-quality study based on a large community sample (Breslau et al., 1998). People can recover from stressful and traumatic situations, as is made evident with this information. According to the Resilience Scale (Connor & Davidson, 2003), there are five different factors of resilience, that can be interpreted as: (1) a sense of personal competence and tenacity; (2) tolerance of negative affect and acceptance of the strengthening effects of stress; (3) acceptance of change and cultivating secure relationships; (4) sense of control; (5) spiritual influences (Iacoviello et al., 2014). Elements 1, 2, and 4 are cognitive components are related to the core beliefs and patterns of thinking within a person. The 3rd and 5th elements are behavioral and are incorporated when a person cultivates relationships and social support networks. Having a dedicated support system enables a person who has gone through a traumatic experience to have more resilience. The 5th factor also ties in an existential component, emphasizing that one's spirituality is important. Given these elements of the resilience scale, the psychosocial factors used to promote resilience are as follows: optimism, cognitive flexibility, active coping skills and maintaining a social support network, physical activity, and embracing a personal moral compass (Connor & Davidson, 2003).

The North American Association of Christians in Social Work (NACSW) Statement of Faith and Practice expresses that "Christians in social work ought to examine and evaluate all human ideologies and social work theories and methods as to their consistency with the Bible, their consciences, social laws, and professional codes of ethics" (Keith-Lucas, 1980, para. 5). Being able to properly integrate faith into the social

work practice as a Christian social worker through a process of ethical reasoning, all while respecting the spiritual diversity of clients, is a crucial component of building up this spiritual aspect of resilience.

Conclusions

Given the previously noted information from the literature review and interviews, there are many positive effects from those clients who successfully completed a DBT program. Although there were cases of clients dropping the program, most cases showed that clients who were diligently involved in a highly structured DBT program were extremely successful. Many clients no longer needed even the supplemental mental health services they had been receiving due to the rigors of the DBT program and the lasting resources that had been provided.

Some proposed ways that a clinical social worker, or any type of therapist, could promote resilience within individuals, and ultimately within communities, would be to encourage the following to their clients: to find and identify with a resilient role model; establish a supportive social network; face fears instead of avoiding them; attend to one's physical well-being; and identifying, utilizing, and fostering one's particular character strengths. Those in the social work profession often talk about the idea of a *strengths-based perspective,* where a social worker practices from an approach that centers on clients' abilities, talents, and resources to help them with their problems and goals (Kim, 2017). If more social workers were actively advocating for healing through resilience for their clients, the mindset that is required for a person to make it through the DBT program would be better achieved.

Clinical social workers who assist their clients in taking meaningful and intentional action are helping to fix the impact of the problem present in the life of clients through DBT. This trauma intervention assists clients in living a more satisfactory life. Some guidelines for social workers to follow in order to foster resilient clients and communities would be as follows: assessing the resources that are present and attending to the area of greatest social vulnerability first; engaging clients in a meaningful way from preparation to action to recovery; utilizing preexisting connections and relationships for the purpose of continuing support once therapy is done; intervening and protecting social supports; and exercising flexibility by focusing on the information and communication networks that are already in place (Norris et al., 2008). In dealing with clients who have undergone some sort of trauma, it would be to the benefit of clinical social workers to understand where the clients are coming from to properly treat clients through the trauma intervention of DBT.

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