Approximately 60% of individuals with BPD suffer from severe co-occurring posttraumatic stress disorder (PTSD), mostly related to sexual abuse and other maltreatment during childhood. Even successful standard DBT requires additional treatment with these clients. In cooperation with M. Linehan at the Central Institute of Mental Health, Mannheim, a three-month (45-session) residential treatment program has been developed. DBT-PTSD integrates rules of residential DBT and integrates trauma-specific treatment modules such as exposure procedures, processing of dysfunctional guilt, shame, and disgust, compassion focused mindfulness and body therapy.

Efficacy of DBT-PTSD was examined by randomized controlled trial. Data revealed large effect sizes (d=1.4) extremely low drop-out rates, and good response rates. Of particular importance seems that neither the severity of BPD, nor the number of self-harm behaviors at the beginning of the therapy had negatively affected treatment outcome.

Dissociation is a major factor that negatively affects many trauma-focused therapies, rendering them less useful than they might be otherwise. In DBT-PTSD, computer-assisted exposure homework uses a specialized program developed for DBT-PTSD (Morpheus). Morpheus works by using loud sounds and a flashing light when there is latency between listening to the exposure recorded during session, and responding to spontaneous queries generated by Morpheus. Morpheus queries current distress and primary emotions while listening to the pre-recorded trauma exposure. If the client is too distressed or nonresponsive, Morpheus generates games or DBT-PTSD skills practice, re-rating primary emotions and distress until the client indicates that they are regulated enough to continue exposure homework. The interactive nature of Morpheus and in-session DBT-PTSD trauma exposure reduces the potential for dissociation and other avoidance strategies. Morpheus output allows tracking of individual client data from exposure practice in relation to dissociation, distress, and primary emotions, enabling tailored DBT-PTSD treatment to each individual client. This has likely contributed to the success of what is otherwise a relatively short-term program (45 sessions) for a difficult-to-treat population with respect to refractory co-principal diagnoses.

Other unique aspects of DBT-PTSD are therapy modules dedicated to:
(i) Reclaiming one’s life with respect to interests, vocation, and social activities,
(ii) Discovering or re-engaging in one’s sexuality and sexual identity,
(iii) Discovering or re-engaging in romantic intimacy with non-violent, non-exploitive partners, and
(iv) Cultivating an identity outside of having a trauma history or being a recipient of mental health services.
These therapeutic tasks are achieved through structured DBT-PTSD interventions that begin at the commencement of therapy and progress until its termination.

Dr. Bohus completed his M.D. at Freiburg Medical School and did his residency in Psychiatry and Neurology at Freiburg Medical School. He completed his specialty in Psychiatry and Psychotherapy and in Psychosomatic Medicine. Since 2003 he holds the chair of Psychosomatic Medicine and Psychotherapy, Heidelberg University, and is Medical Director at the Central Institute of Mental Health, Mannheim. He has received several awards for psychotherapy research. He is board member of the German Association of Psychiatry DGPPN, President of the European Society for the Study of Personality Disorders (ESSPD), president of the German Association for DBT and Co-chair of the International Strategic Planning Meeting for Dialectical Behavior Therapy (SPM). He has currently published 230 articles and book chapters, mainly on mechanisms of psychotherapy, borderline personality disorders and PTSD.