DBT for Complex Eating Disorders: The First Sessions

Charlotte Thomas, LCSW
CREDN Annual Conference
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Our goals

Upon completion of this presentation, participants will:

• Explain the structure and goals of the first DBT sessions
• Describe the biosocial model of DBT
• Understand the timing and use of strategies such as dialectics, behavioral chain analysis, and diary cards
• Explain how and why DBT varies from other standard forms of treatment
Mindfulness

- The quality or state of being mindful (attentive, thoughtful, intentional)
- A particular way of paying attention and directing one’s focus, in the present moment, without judgment.
- Awake!
- The repetitive act of directing and redirecting one’s attention to only one thing moment by moment.
- Attention control
Why DBT?

• DBT was developed for multi-diagnostic, severe, difficult-to-treat chronically suicidal individuals with both Axis I & Axis II disorders, including those with BPD.
Why Do We Need DBT for ED When Other EBP Exists?

- **ED and BPD:**
  - More hospitalizations (Wonderlich, Fullerton, Swift & Klein, 1994)
  - More psychological disturbance (BenPorath, Wisniewski & Warren, 2009)
  - 2x rates of NSSI (Dulit et al, 1994)
  - 4x rates of suicidal behavior (Herzog et al, 1992)

- **EBPs have no protocol for managing suicide/NSSI yet many ED patients engage in these behaviors** (Svirko & Hawton, 2007)
  - AN-R: 13-42%
  - BN: 26-55%
  - AN-BP: 27-68%
Which ED Patients May Require DBT?

• Have already tried TAU (CBT, IPT, higher levels of care) and these have failed
• Multiple attempts at treatment
• History of treatment interruption or low-treatment adherence
• History of ‘burning-out’ or otherwise alienating clinicians/treatment team
• Co-morbidities
• Current/past suicidality or NSSI
What does outpatient DBT do differently?

- Dialectical Stance generates movement and collaboration
- “Consult to client” shifts clinician away from directly intervening in the environment
- Attention to multiple problems at once using a target hierarchy to guide intervention
- Groups focus entirely on skills acquisition and practice
Our map for the next 30 minutes…

• Present a composite client
• Explore outpatient session content, paying attention to the ‘why’ (rather than the ‘how’)
• Review session outcomes
Our composite client

- 35 year old male, white, straight, currently in a relationship and living with his partner (wife)
- Has just left job (LPC at a university counseling center)
- Referred to DBT by outpatient therapist
- Is seeking help for trauma-related symptoms
  - Nightmares nightly
  - Non-suicidal self injury occurring multiple times every day (burning with various intensity of harm)
  - Avoidance of sexual intimacy with wife for the last 9 months
  - Decrease in ability to focus at work led to decision to leave not only job, also career
  - Recurrent intrusive thoughts of abuse
  - Paranoia about others talking about self in public
Our composite client (cont)

- Reports sub-threshold eating disorder symptoms including:
  - Desire to increase strength and tone “everyone feels this way, right?”
  - Eats well when wife is home (she is a chef; feeds our client)
  - Daily visits to gym for 2-3 hours
  - Otherwise avoids food
  - No recent significant weight loss
  - Low-normal BMI
  - Denies laxatives, diuretics, caffeine pills, other intentional means of weight loss
  - No history of treatment for an ED
  - Denies having an ED
  - No identified distress beyond what looks normative
Intake sessions (1-3):
MHA & Treatment Plan

• Mental Health Assessment paying attention to:
  – What behaviors the client wants to work on
  – History of treatment and behaviors
  – Where do learning paradigms fit into the behavior
  – Understanding behaviors in terms of WHAT, WHEN, WHERE, HOW, HOW-MUCH, WHY
  – Life threatening behavior in the present and the past
    • Current level of risk? Past level of risk? Most recent? Most dangerous/lethal?
    • What is the behavioral function of this behavior?
• Treatment Plan
  – Behavioral, concrete, measureable
  – Organization: Targets or modes of dysregulation
How does the Biosocial Model help?

- Biological Vulnerability To Emotion
- Invalidating Environment
- Target Behavior
Biosocial Conceptualization

• Biological
  – Family history of diagnoses including substance abuse
  – Emotional vulnerability and reactivity: the ‘sensitive kid’ who internalized and was hard on self; very sad and isolated.
  – Early onset of suicidality; first hospitalized as adolescent
  – PTSD has changed the brain

• Social: The Invalidating Environment
  – Brother = Golden Child, loved and supported by Mom
  – Mom ignored occurrence of abuse and client attempts to gain safety
  – Dad = Sexual Abuser; Invalidated concerns of client about abuse: ‘you’re wrong/stupid’

• What maintains the behaviors? Operant, respondent, biological, modeling?
Motivation & Commitment

- This is a NECESSARY task to be completed before treatment can engage

- Questions:
  - Can we agree on what the focus will be?
  - Can we agree to work together?
  - Why does the client want to do this work? Why not? What will get in the way?
  - Are client goals within my own limits?

- Psychoeducation about:
  - DBT: what, why, how, who, when
  - Problematic behaviors: why do they develop, what keeps them active

- HOMEWORK: start keeping a diary card
Session structure: Targets

- **Target 1: Life Threatening Behavior**
  - What gets in the way of staying alive?
  - Suicide, NSSI, medically documented instability caused by ED behaviors

- **Target 2: Therapy Interfering Behavior**
  - What gets in the way of therapy working?

- **Target 3: Quality of Life Interfering Behavior**
  - What (else) gets in the way of BUILDING A LIFE WORTH LIVING?
  - ED behaviors
  - Job/Education related
  - Interpersonal
# Session #1 Diary Card

## PTSD Recovery Diary Card

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**RATING SCALE FOR EMOTIONS AND URGES:**
0 = None, 1 = Minimal, 2 = Mild, 3 = Moderate, 4 = Strong, 5 = Intense

- U = Urge (0-5)
- Bx = Behavior (Y/N)
- C = Time

**RATING SCALE FOR SKILL USE:**
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**Homework:** Complete Diary Card

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*Not sleeping well at night, Napping during day*
Session #1

• Warmth and hope in a straightforward manner
• Diary Card:
  – Client reports engaging in NSSI daily, 6-12 times/day (LTB)
  – Minimal data about restriction (QOL)
  – No change to exercise reported as baseline (QOL)
  – Client reports daily intrusive memories, 6-12 times/day (QOL)
  – Nightmares every night (QOL)
• Notice, while using target hierarchy:
  – What is the most distressing experience this week?
• Teach:
  – Behavior analysis
  – Nightmare protocol
• HOMEWORK: Nightmare protocol; client likes the strategies that focus on recurrent intrusive thoughts
Session #1 Behavior Analysis

Diagram:

- **Thoughts**
  - I'm sad (around)
  - I'm damaged

- **Prompting Event**
  - Intrusive Memories

- **Emotions**
  - Guilt
  - Shame
  - Anger

- **Problem Behavior**
  - Burning self

- **Short Term Consequence**
  - Relief

- **Long Term Consequence**
  - Increased guilt/shame
  - Injury - need to hide
Session #2: Diary Card

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**Homework:**
Draw a map of eyes @ bedtime; TIPP

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Easier to
80% to sleep

PTSD Recovery Diary Card

Portland DBT Institute
Session #2

- Continue to focus on building rapport with straightforward warmth and curiosity
- Diary card:
  - Client slept better
  - No change in NSSI, intrusive thoughts, or reported restriction
- Notice, including target hierarchy:
  - Is there a connection between NSSI and intrusive memories?
  - Behavior Chain
- Teach:
  - Nightmare protocol focusing on changing the ending
- HOMEWORK: change the ending, ask wife for help
Session #3: Diary Card

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Homework:
Change ending of nightmare, use help map
Session #3

• **Diary Card:**
  – Only one nightmare this week
  – Continues to use “map” strategy with significant effectiveness
  – 50% reduction in frequency of NSSI, still occurring daily
  – Increased restriction

• **Notice:**
  – What has contributed to decline in frequency of NSSI?
  – What has contributed to increase in intensity of restriction?

• **Teach:**
  – What is possible connection between decrease in NSSI and increase in restriction (BCA)
  – Dialectics as applicable to what client reports today
  – Surfing the urge
  – TIPP

• **HOMEWORK:** schedule with RD, practice surfing the urge and paced breathing
Session #3 Behavior Chain

Behavior Chain: skipping breakfast

Wake up & feel content → cuddling → relief → intrusive memory → make excuse "shower" → skip breakfast → make excuse "calm" → shame decreases → feel numb → intense shame → "can't let her know" (hide)

Vulnerabilities:
- Skipped dinner "wasn't hungry"
- "Freaked out" last night when attempted intimacy

Proud no NSSI

Shame remains intense → able to avoid NSSI → practice TIPP (temperature) → decide no NSSI

Immediate physical arousal
Session #4

• Diary Card:
  – No NSSI all week
  – No nightmares
  – Increased awareness of restriction;
  – Focused skills practice, experienced as effective
  – Enjoying skills group
  – Saw RD and has HW assignment to eat more protein daily

• Notice:
  – Client feeling great about DBT. What is working? What has changed?
  – What has contributed to NSSI extinguishing? What does client notice now about the intrusive thoughts?

• Teach:
  – Dialectic of wanting to be intimate with wife AND finding intimacy to be highly triggering
  – Use of exposure to treat

• HOMEWORK: practice intimacy with partner in a manner that communicates safety
Progress to date and what’s next?

• Progress:
  – Decrease: NSSI, nightmares
  – Increase: awareness/acceptance of restriction as a problem related to other behaviors, skills use, sense of hope and mastery

• What’s next:
  – Continued work on restriction (willingness, motivation/commitment, behavioral change)
  – Intimacy middle path
Summarizing Thoughts: Why DBT excites me

• Dialectics:
  – Movement from denial to acceptance of eating disorder behavior
  – Acceptance of transaction between seemingly unrelated target behaviors
  – Ability to hold both understanding and condemnation of Mom’s behaviors
  – Focus on looking for constant change instead of a concrete solution
  – Warm and straight-forward in the same moment
• Focus on behavior and finding a path of change
• Mindfulness to the present, not the past or the future
• Strategies: BCA, psychoeducation, skills coaching, exposure
• Effective attention to multiple problems without expectation of addressing every problem every session
Selected Upcoming Trainings

• Diving Deep into DBT Skills, April 7-8
• Working Well with the Suicidal Patient, May 12
• DBT for Eating Disorders, May 19-20
• Mindfulness and Meditation Retreat, June 22-25
Contact Information

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Portland OR 97239

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www.pdbti.org