Portland DBT INSTITUTE

DBT for Complex Eating Disorders: The First Sessions

Charlotte Thomas, LCSW

CREDN Annual Conference

February 25, 2017

5200 SW Macadam Ave, Suite 580 Portland OR 97239 | (503) 231-7854

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

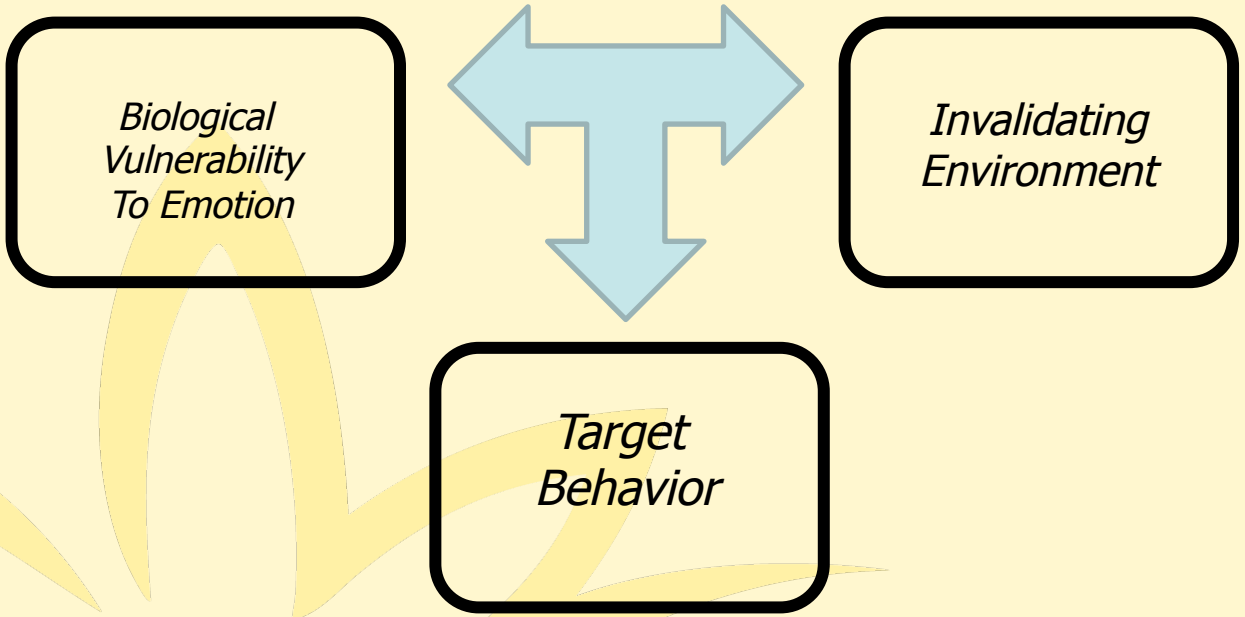
Our composite client (cont)

- 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?



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?

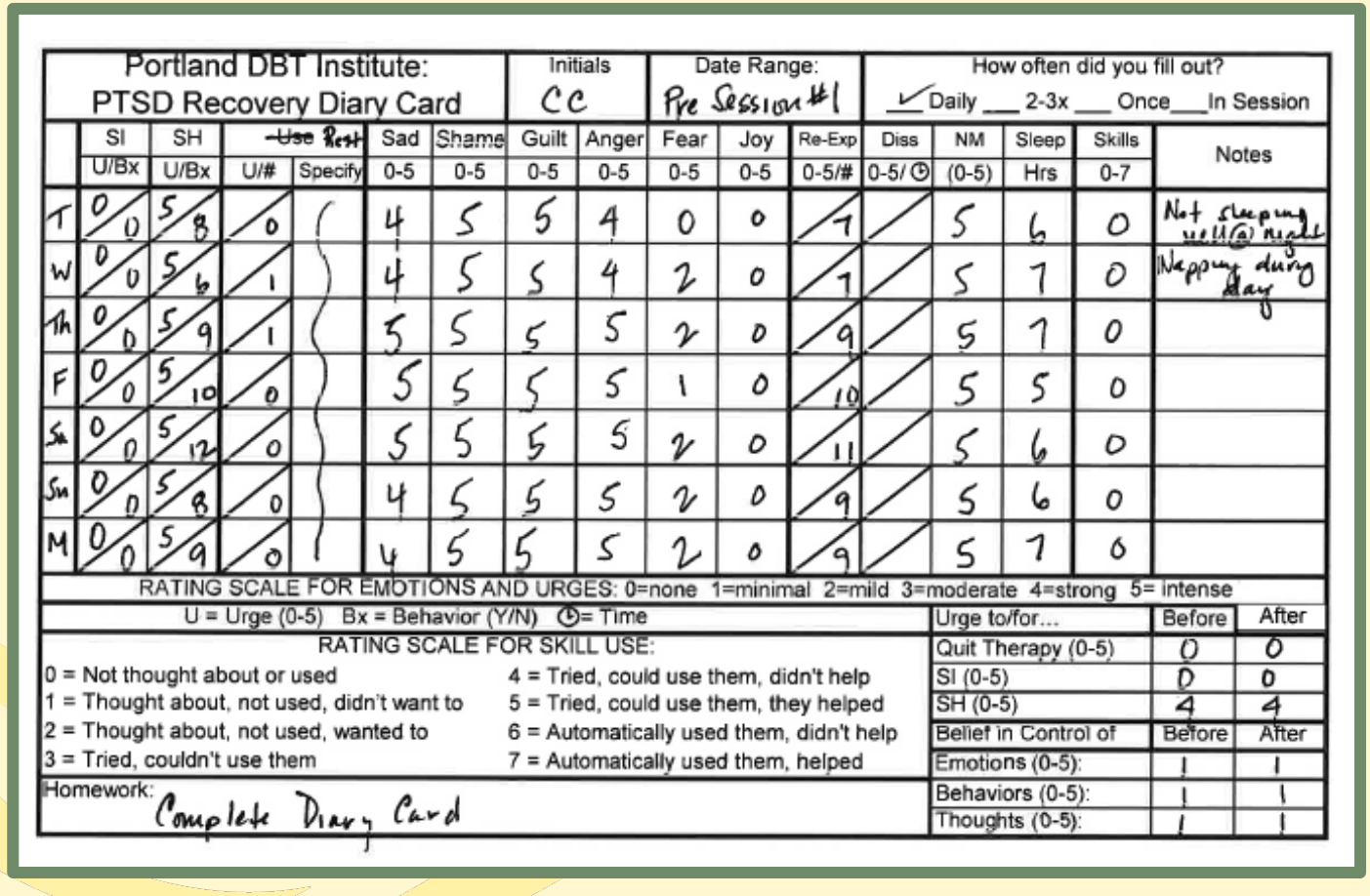
Motivation & Commitment

- 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



Portland DBT Institute: PTSD Recovery Diary Card

Initials: CC

Date Range: Pre Session #1

How often did you fill out? ✓ Daily ___ 2-3x ___ Once ___ In Session

	SI U/Bx	SH U/Bx	~~Use~~ Rest U/#	Specify	Sad 0-5	Shame 0-5	Guilt 0-5	Anger 0-5	Fear 0-5	Joy 0-5	Re-Exp 0-5/#	Diss 0-5/⏲	NM (0-5)	Sleep Hrs	Skills 0-7	Notes
T	0/0	5/8	/0	(	4	5	5	4	0	0	/7	/	5	6	0	Not sleeping well @ night
W	0/0	5/6	/1	)	4	5	5	4	2	0	/7	/	5	7	0	Napping during day
Th	0/0	5/9	/1	)	5	5	5	5	2	0	/9	/	5	7	0	
F	0/0	5/10	/0	)	5	5	5	5	1	0	/10	/	5	5	0	
Sa	0/0	5/12	/0	)	5	5	5	5	2	0	/11	/	5	6	0	
Su	0/0	5/8	/0	)	4	5	5	5	2	0	/9	/	5	6	0	
M	0/0	5/9	/0	)	4	5	5	5	2	0	/9	/	5	7	0	

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) ⏲= Time

RATING SCALE FOR SKILL USE:

0 = Not thought about or used
1 = Thought about, not used, didn't want to
2 = Thought about, not used, wanted to
3 = Tried, couldn't use them
4 = Tried, could use them, didn't help
5 = Tried, could use them, they helped
6 = Automatically used them, didn't help
7 = Automatically used them, helped

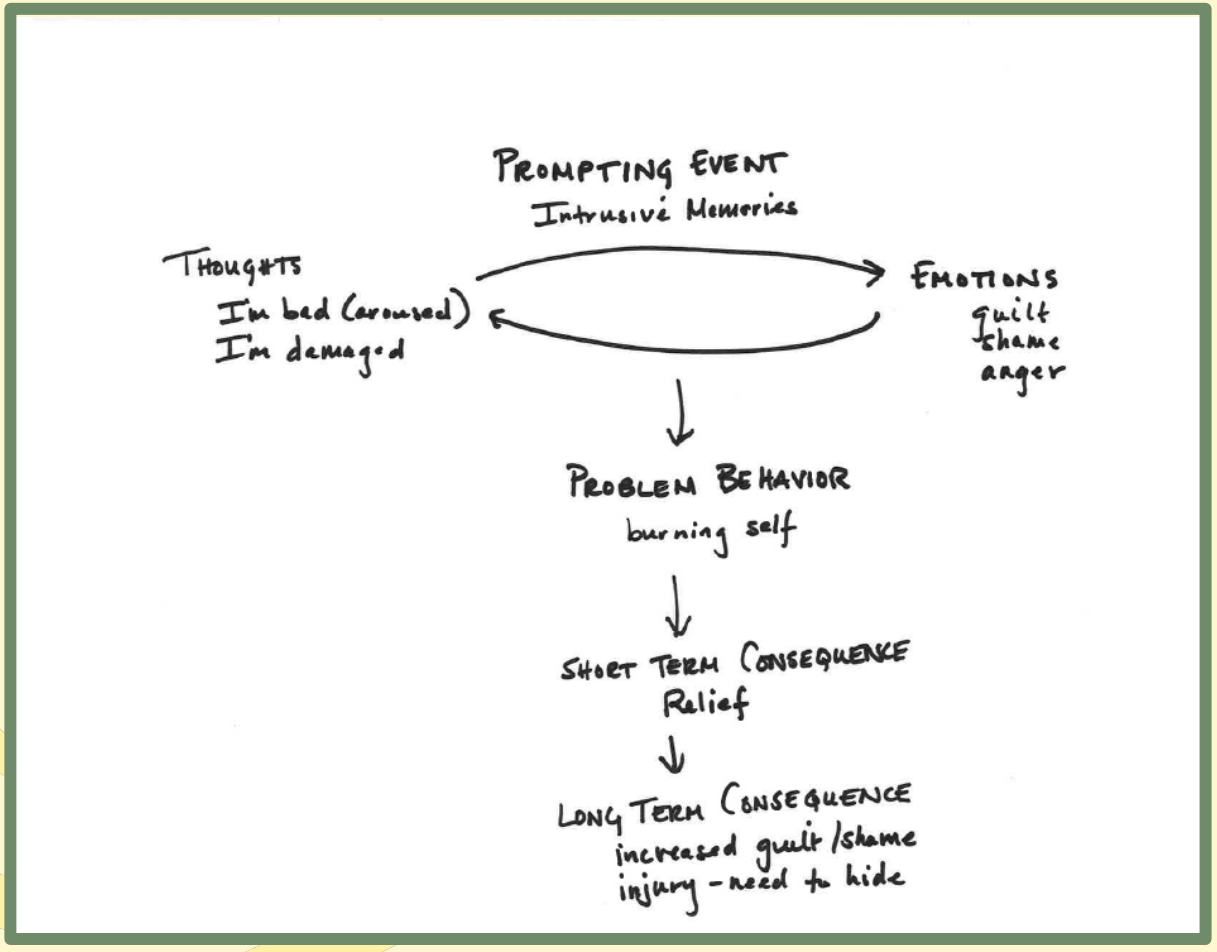
Homework: Complete Diary Card

Urge to/for...	Before	After
Quit Therapy (0-5)	0	0
SI (0-5)	0	0
SH (0-5)	4	4
Belief in Control of	**Before**	**After**
Emotions (0-5):	1	1
Behaviors (0-5):	1	1
Thoughts (0-5):	1	1

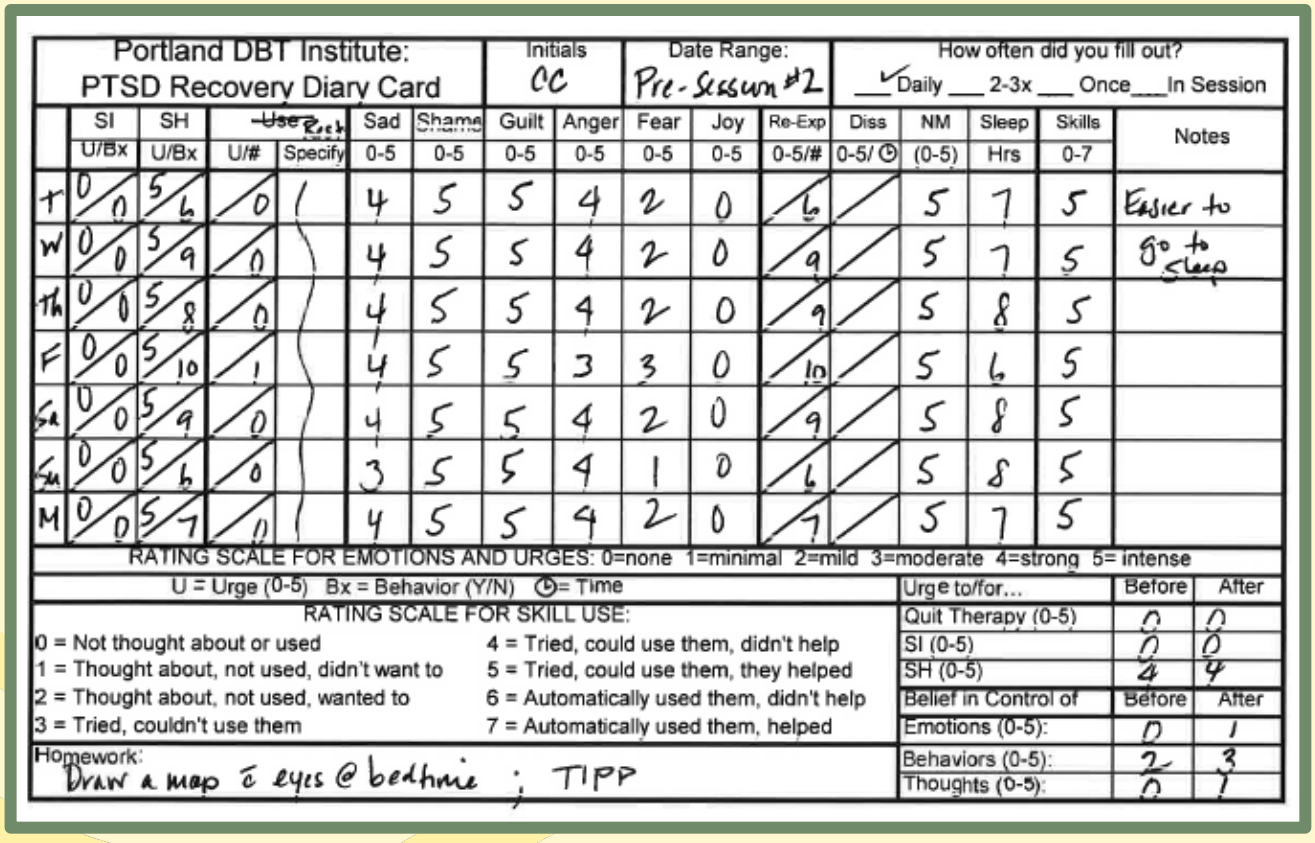
Session #1

- 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



Session #2: Diary Card



Portland DBT Institute: PTSD Recovery Diary Card

Initials: CC | Date Range: Pre-Session #2 | How often did you fill out? ✓Daily ___ 2-3x ___ Once ___ In Session

	SI U/Bx	SH U/Bx	~~Use~~ Rock U/#	Specify	Sad 0-5	Shame 0-5	Guilt 0-5	Anger 0-5	Fear 0-5	Joy 0-5	Re-Exp 0-5/#	Diss 0-5/⏲	NM (0-5)	Sleep Hrs	Skills 0-7	Notes
T	0/0	5/6	/0	(	4	5	5	4	2	0	/6	/	5	7	5	Easier to
W	0/0	5/9	/0		4	5	5	4	2	0	/9	/	5	7	5	go to sleep
Th	0/0	5/8	/0		4	5	5	4	2	0	/9	/	5	8	5	
F	0/0	5/10	/1		4	5	5	3	3	0	/10	/	5	6	5	
Sa	0/0	5/9	/0		4	5	5	4	2	0	/9	/	5	8	5	
Su	0/0	5/6	/0		3	5	5	4	1	0	/6	/	5	8	5	
M	0/0	5/7	/0	(	4	5	5	4	2	0	/7	/	5	7	5	

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) ⏲= Time

RATING SCALE FOR SKILL USE:

0 = Not thought about or used
1 = Thought about, not used, didn't want to
2 = Thought about, not used, wanted to
3 = Tried, couldn't use them
4 = Tried, could use them, didn't help
5 = Tried, could use them, they helped
6 = Automatically used them, didn't help
7 = Automatically used them, helped

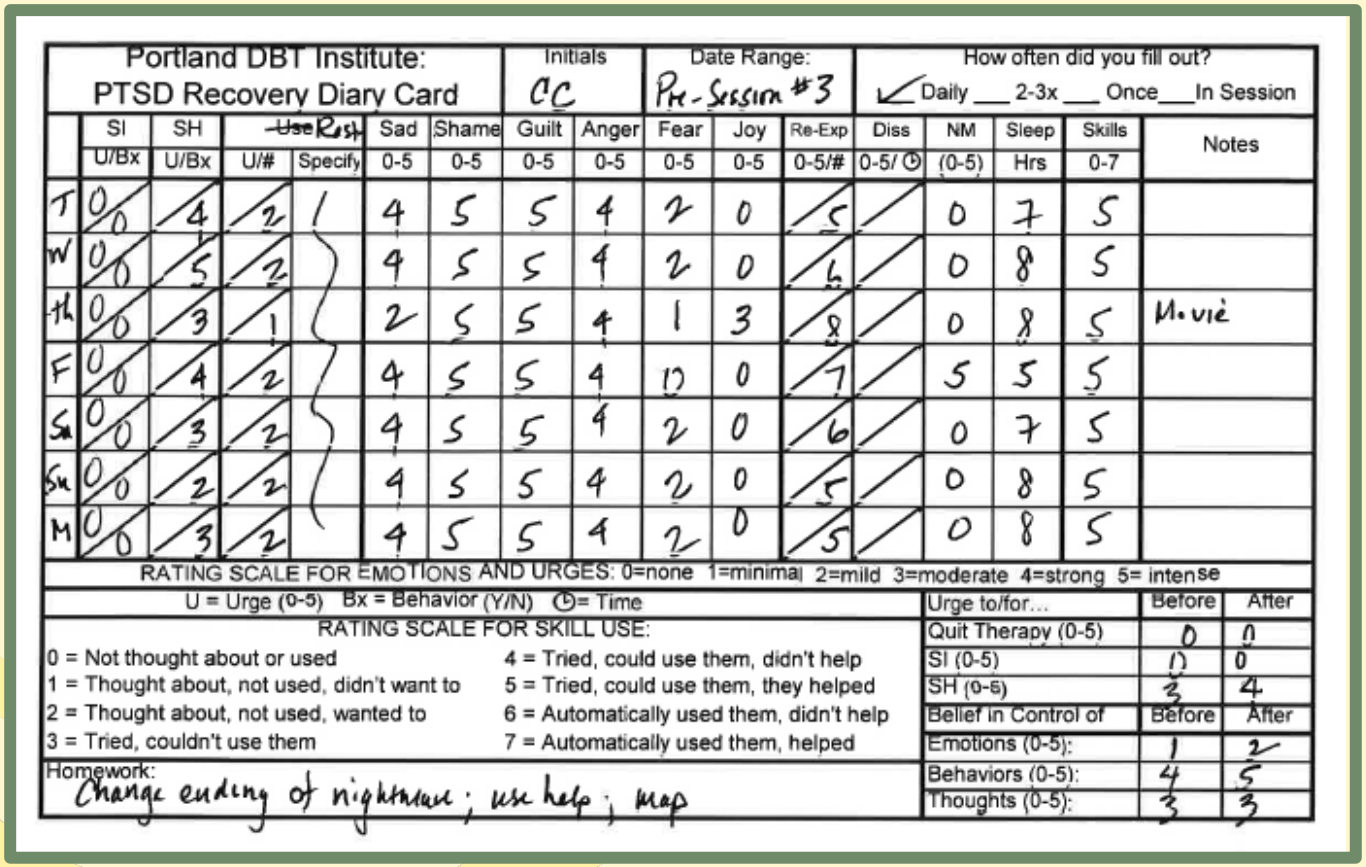
Homework: Draw a map ☆ eyes @ bedtime ; TIPP

Urge to/for...	Before	After
Quit Therapy (0-5)	0	0
SI (0-5)	0	0
SH (0-5)	4	4
Belief in Control of	**Before**	**After**
Emotions (0-5):	0	1
Behaviors (0-5):	2	3
Thoughts (0-5):	0	1

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



Portland DBT Institute: PTSD Recovery Diary Card

Initials: CC

Date Range: Pre-Session #3

How often did you fill out? ✓ Daily ___ 2-3x ___ Once ___ In Session

	SI U/Bx	SH U/Bx	~~Use~~ Rest U/#	Specify	Sad 0-5	Shame 0-5	Guilt 0-5	Anger 0-5	Fear 0-5	Joy 0-5	Re-Exp 0-5/#	Diss 0-5/⏲	NM (0-5)	Sleep Hrs	Skills 0-7	Notes
T	0/0	4	2	I	4	5	5	4	2	0	5	✓	0	7	5	
W	0/0	5	2		4	5	5	4	2	0	6	✓	0	8	5	
Th	0/0	3	1		2	5	5	4	1	3	8	✓	0	8	5	Movie
F	0/0	4	2		4	5	5	4	10	0	7	✓	5	5	5	
Sa	0/0	3	2		4	5	5	4	2	0	6	✓	0	7	5	
Su	0/0	2	2		4	5	5	4	2	0	5	✓	0	8	5	
M	0/0	3	2		4	5	5	4	2	0	5	✓	0	8	5	

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) ⏲= Time

RATING SCALE FOR SKILL USE:

0 = Not thought about or used
1 = Thought about, not used, didn't want to
2 = Thought about, not used, wanted to
3 = Tried, couldn't use them
4 = Tried, could use them, didn't help
5 = Tried, could use them, they helped
6 = Automatically used them, didn't help
7 = Automatically used them, helped

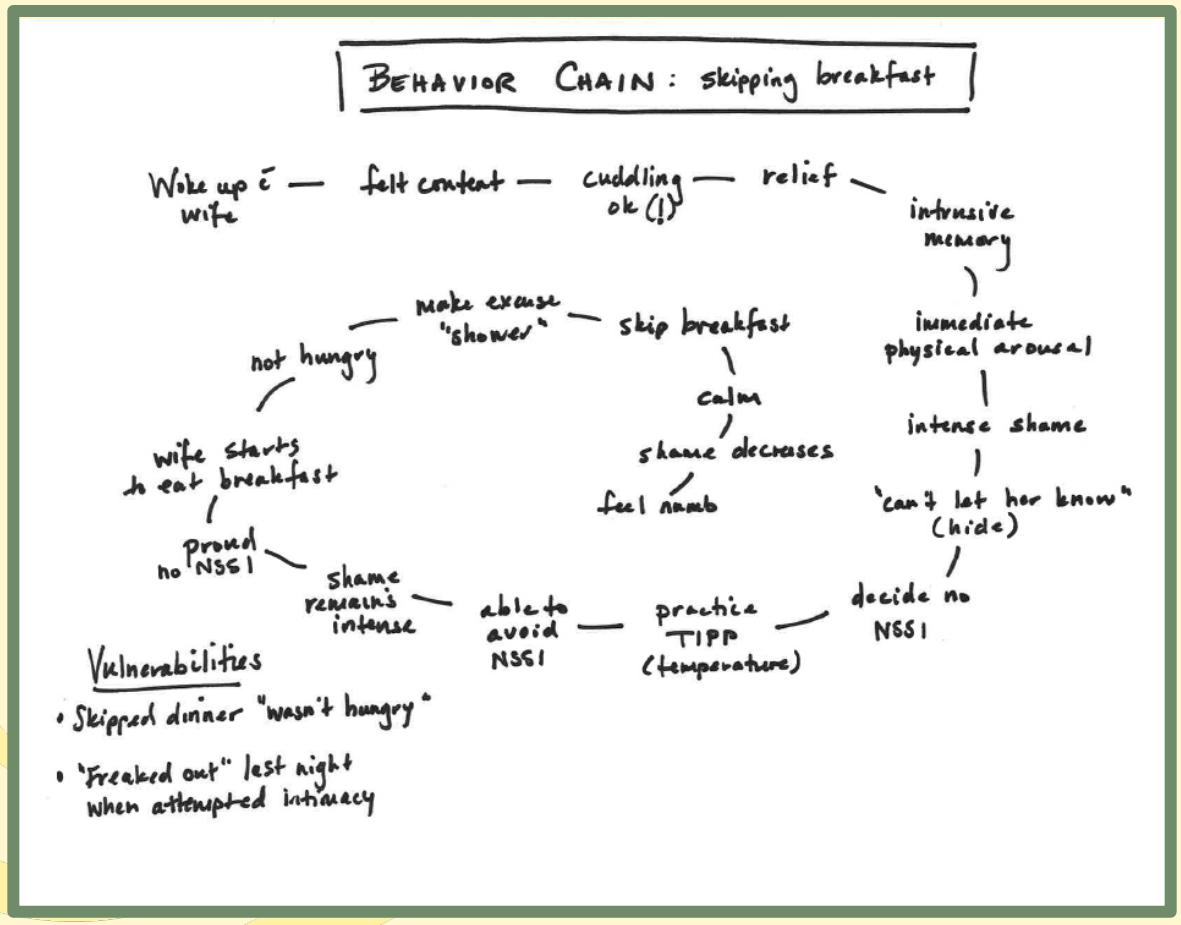
Homework: Change ending of nightmare; use help; map

Urge to/for...	Before	After
Quit Therapy (0-5)	0	0
SI (0-5)	1	0
SH (0-5)	3	4
Belief in Control of	**Before**	**After**
Emotions (0-5):	1	2
Behaviors (0-5):	4	5
Thoughts (0-5):	3	3

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



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

Charlotte Thomas, LCSW

Portland DBT Institute
5200 SW Macadam Ave, Suite 580
Portland OR 97239

CT: 503-290-3277; Main: 503-231-7854; Fax: 503-231-8153

cthomas@pdbti.org; cwilliams@pdbti.org (Training information);
www.pdbti.org