DBT for Complex Eating Disorders: The First Sessions

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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, Winsiewski & 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
  - Recent intrusive thoughts of abuse
  - Paranoid 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, measurable
    - Organization: Targets or modes of dysregulation

How does the Biosocial Model help?

Biological Vulnerability
To-Environment

Target Behavior

Invalidating Environment

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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

- Warmth and hope in a straightforward manner
- Diary Card:
  - Client reports engaging in NSSI daily, 6-12 times/day (LTM)
  - 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

Session #1 Behavior Analysis

- Session #1 Behavior Analysis

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**Session #2: Diary Card**

- 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

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**Session #3: Diary Card**

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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 interaction between decrease in NSSI and increase in restriction (BCA)
  - Dialectics applicable to what client reports today
  - Surfing the urge
- 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 straightforward 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**
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