Adapting Dialectical Behavior Therapy for Binge Eating Disorder and Bulimia Nervosa

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Aim of Today's Workshop

To teach the basics of adapting Dialectical Behavior Therapy (DBT) for patients who binge eat and/or purge

Outline of Talk: Four Sections

Section 1. Setting the Stage

1. Why Apply DBT for Eating Disorders?

Section 2. Pretreatment and Early Sessions (1& 2):

1. Brief Introduction to DBT
2. Commitment and Orientation to the Model

Outline of Talk: 4 Sections

Section 3. Application of the Skills within an Adapted Three Module Program

1. Mindfulness Module
2. Emotion Regulation Module
3. Distress Tolerance Module

Section 4. Termination and Relapse Prevention

1. Questions/Discussion

Will include demonstration/role-plays/small group exercises to keep everyone awake!

Why Did I Become Interested in DBT?

?

Why Are You Here?

- Who uses DBT in their practice on a regular basis?
- Who treats patients with binge eating and bulimia on a regular basis?
- Who uses DBT as adapted for patients with binge eating and bulimia?
- What do you hope to learn in this workshop?

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Outline of Talk: Section 1

Section 1. Setting the Stage

1. Why Apply DBT for Eating Disorders (EDs)?

- Brief Review
  - Basic Definitions
    - Binge episode, Binge Eating Disorder, Bulimia Nervosa
  - Current Leading Treatment Models for BED and BN
    - CBT and IPT Models
    - Treatment outcomes post CBT or IPT
  - Introduction to Affect Regulation Model
    - Rationale for Adaptation of DBT to BED and BN
  - Research Findings

Outline of Talk: Section 1

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Section 1: Brief Review

How to Define a Binge Episode?

- Eating, in a discrete period of time (e.g. within any 2-hour period), an amount of food that is definitely larger than most people would eat during a similar period of time and under similar circumstances
- A sense of lack of control over eating during the episode (e.g. a feeling that one cannot stop eating or control what or how much one is eating)

Binge Eating Disorder (BED)

- Recurrent episodes binge eating
- At least 1/week for 3 months
  - Binge episodes are associated with 3 or more:
    - Eating much more rapidly than normal
    - Eating until feeling uncomfortably full
    - Large amounts of food when not feeling physically hungry
    - Eating alone because of being embarrassed by how much one is eating
    - Feeling disgusted with oneself, depressed, or very guilty after overeating
  - Absence of compensatory behaviors

Section 1: Brief Review

Bulimia Nervosa Criteria

- Binge eating: Recurrent episodes of rapidly eating large amounts of food over discrete time period, usually < 2 hours
- Lack of control felt during the binge (i.e., unable to stop)
- Recurrent compensatory behavior to prevent weight gain
  - Vomiting, Misuse of laxatives & diuretics, Over-Exercise, Fasting
- On average, at least 1 binge/purge episode per week for at least 3 months

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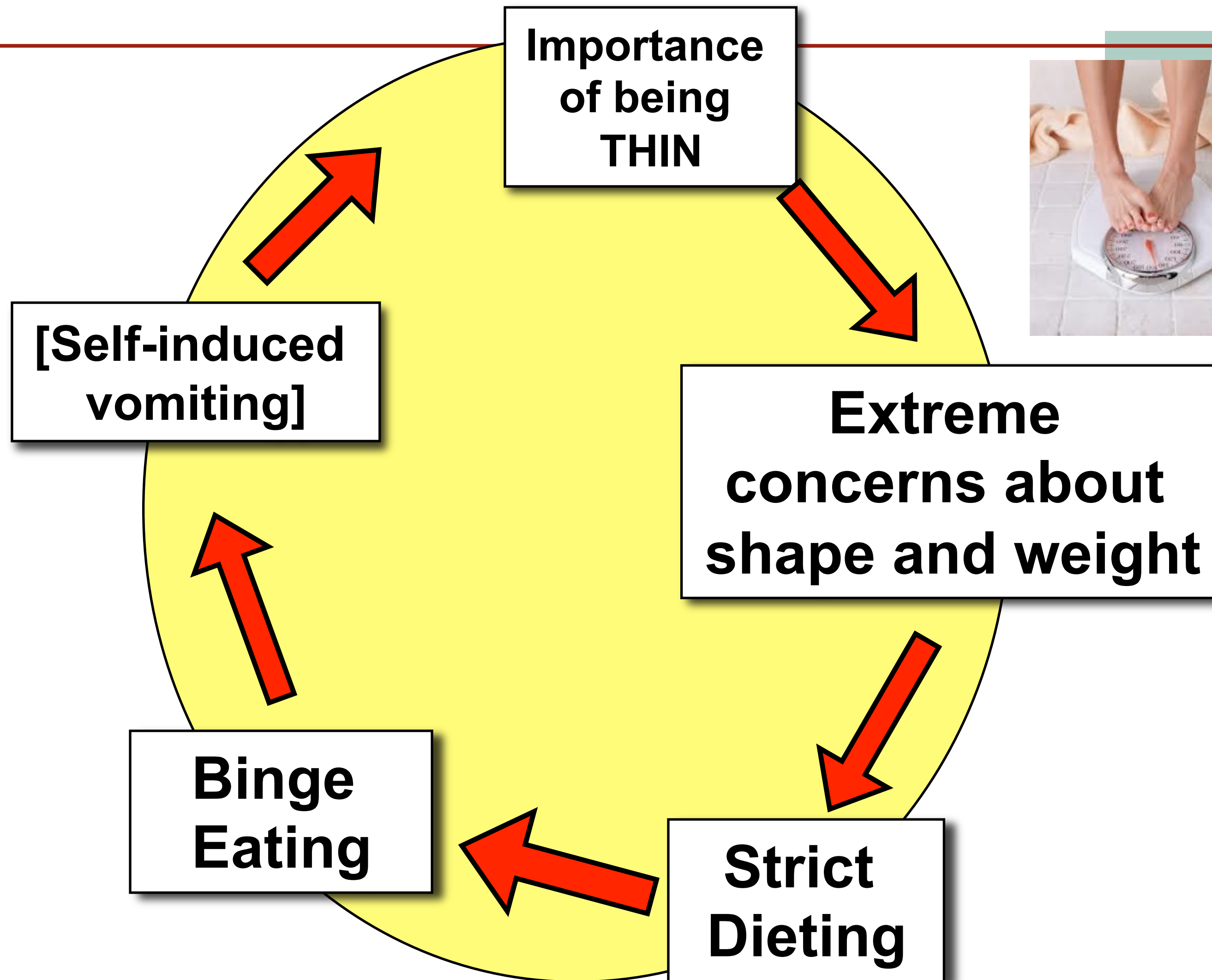
CBT Model for Binge eating and Bulimia: Primary Role on Reducing Dietary Restraint

Extreme dieting driven by **dysfunctional beliefs** about the importance of **weight and shape**

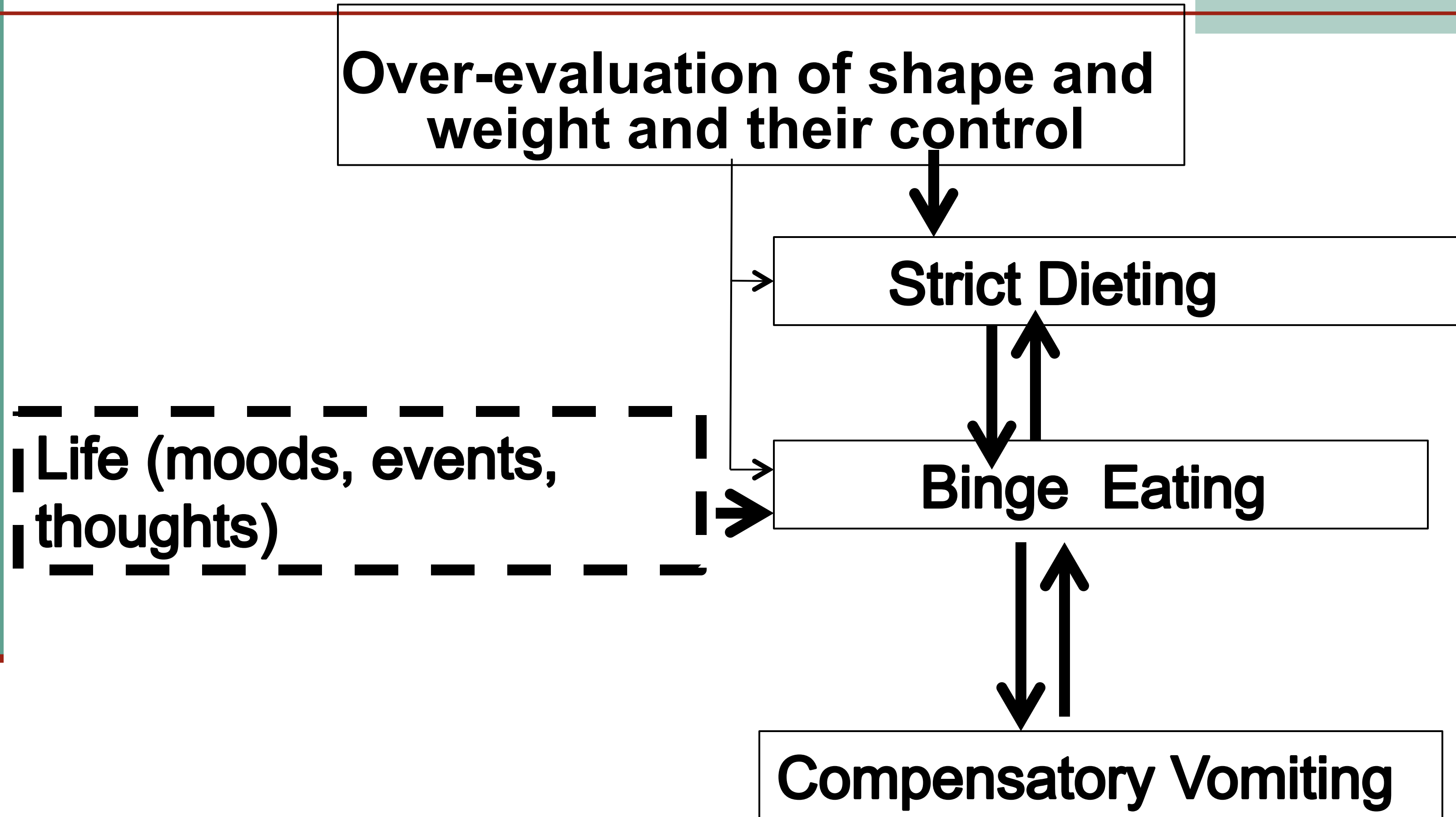
Binge eating and/or purging

CBT Model for Binge Eating and Bulimia: Primary Focus on Reducing Dietary Restraint

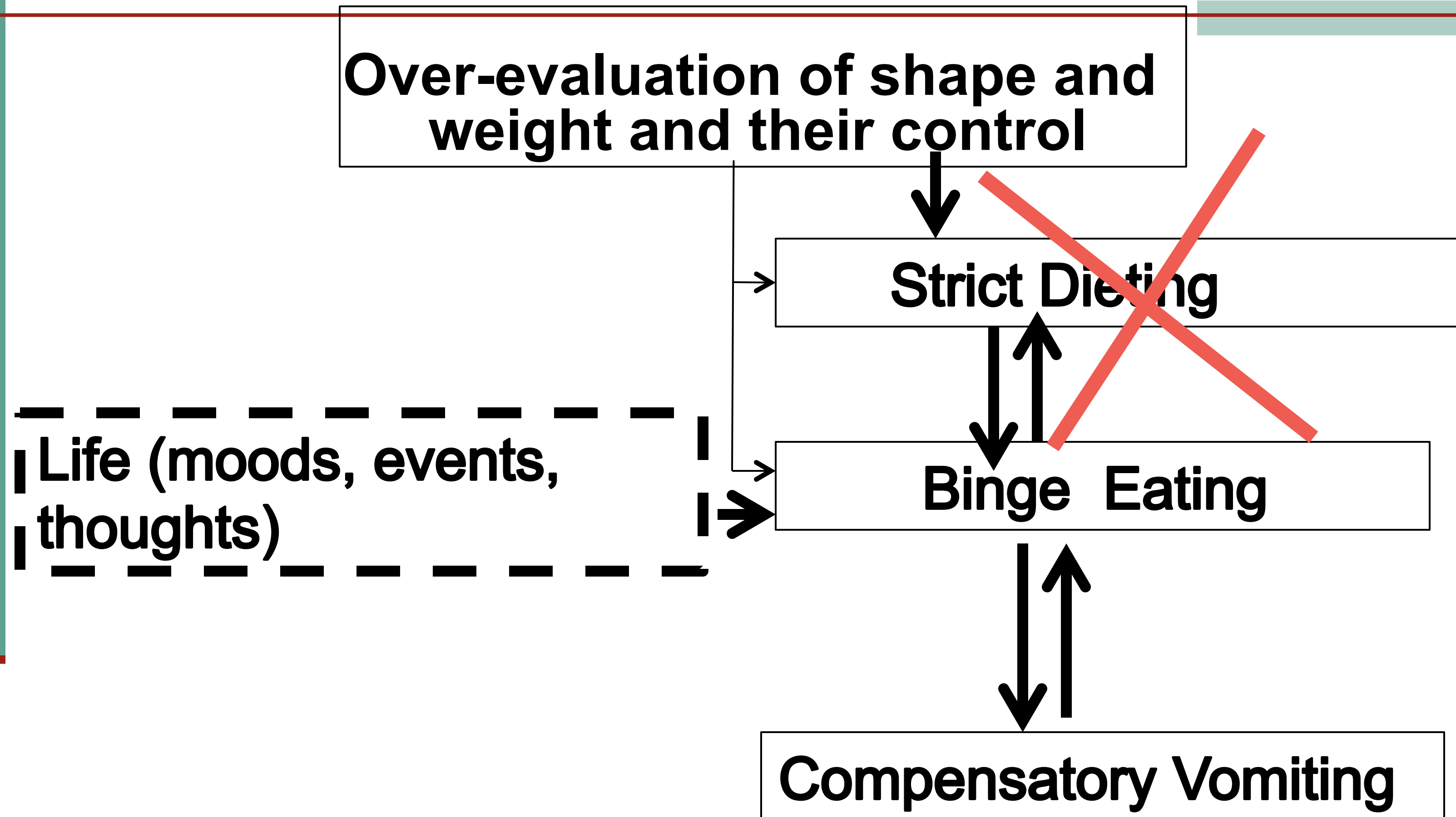


From Wisniewksi L., citing Fairburn, Marcus, & Wilson (1993, p.369)

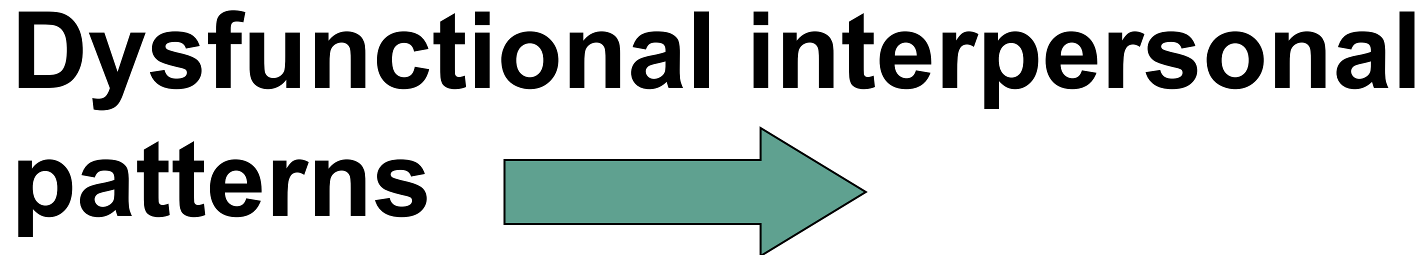
CBT Model of Eating Disorders



CBT Model of Eating Disorders



Interpersonal Psychotherapy (IPT) for Binge Eating and Bulimia: Primary Focus of Interpersonal Factors



Binge eating and/or purging

- Use therapy to actively and systematically bring about changes in dysfunctional interpersonal patterns via role playing, etc. and focus on:

*Role Transitions

*Interpersonal Disputes

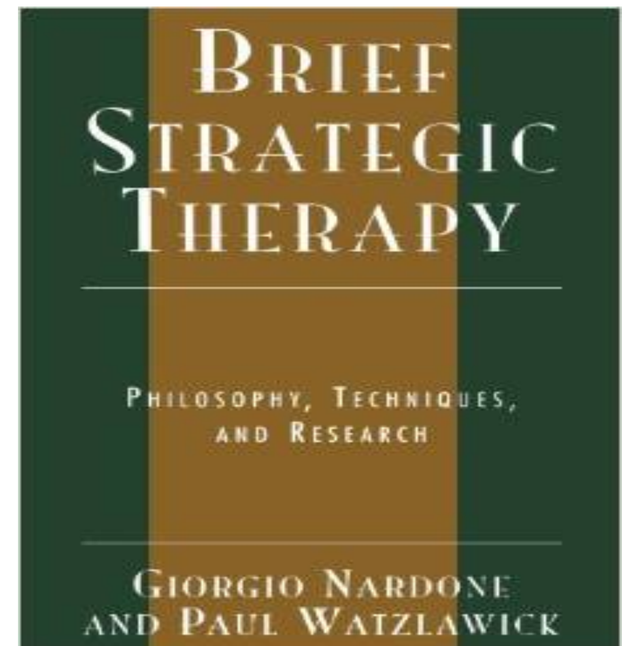
*Unresolved Grief

*Interpersonal Deficits

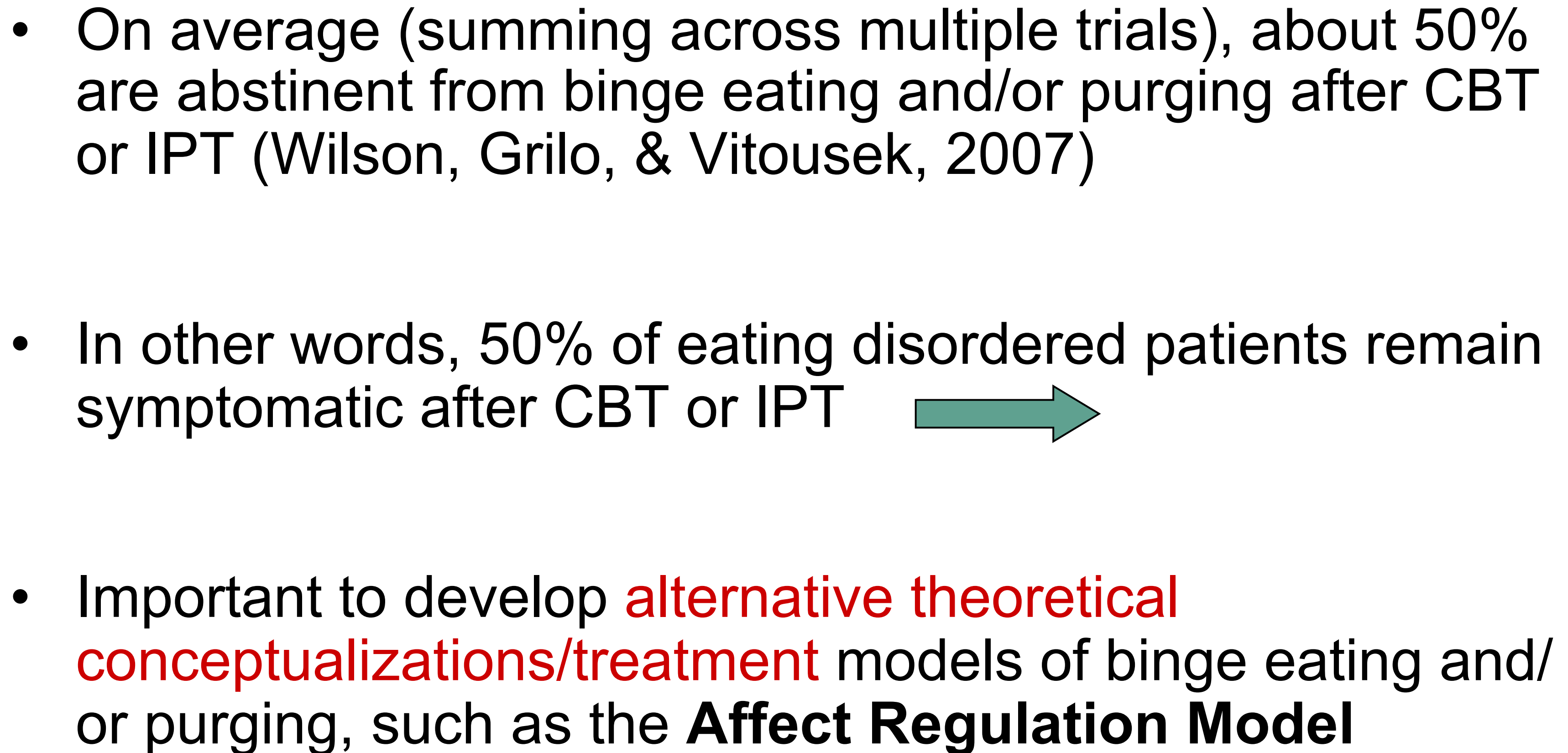
(Wilfley et al., 1993, 2002).

Brief Strategic Therapy for Binge Eating and Bulimia: Nardone

- Focus on understanding how the problem (i.e., binge eating and/or purging) functions, not why it exists
- Failed attempts to solve the problem make the problem worse
- The "solution" is the problem



Treatment Outcomes: Abstinence Rates for BED/BN Clients after CBT, IPT, Strategic



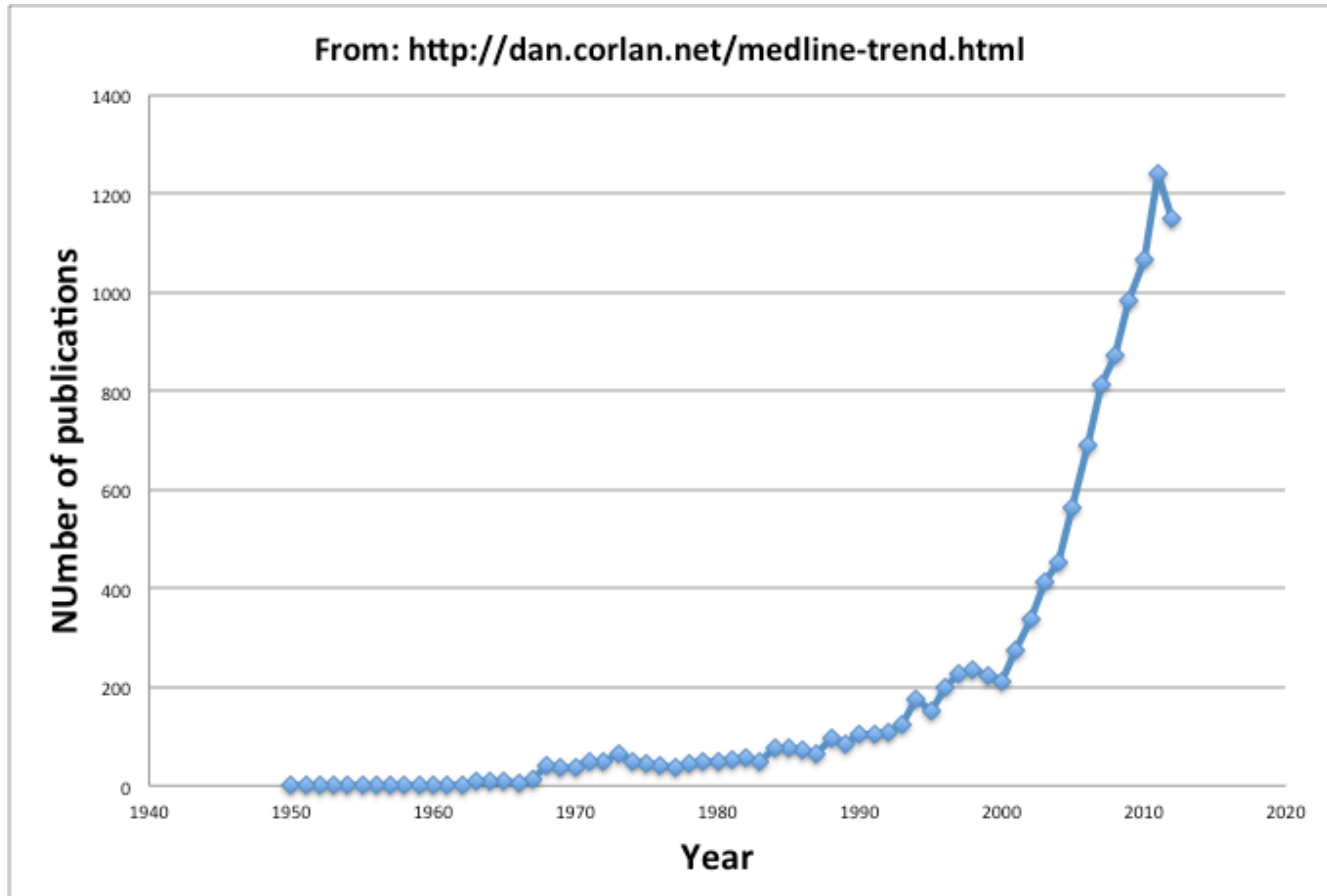
- On average (summing across multiple trials), about 50% are abstinent from binge eating and/or purging after CBT or IPT (Wilson, Grilo, & Vitousek, 2007)
- In other words, 50% of eating disordered patients remain symptomatic after CBT or IPT
- Important to develop alternative theoretical conceptualizations/treatment models of binge eating and/or purging, such as the **Affect Regulation Model**

Affect Regulation Model for Binge Eating and Bulimia

Inability to regulate intense emotions (whether triggered by thoughts about food, body image, perfectionism, or interpersonal situations)

Binge eating and/or purging

Has Been a Large Increase in Number of Research Publications/Year on Emotion Regulation



Outline of Talk: Section 1

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Affect Regulation Theory for Binge Eating: Key Hypothesis

Patients with binge eating and/or purging lack skills to adaptively and effectively cope with negative affective states

- Binge eating, purging, and other problematic eating behaviors function to modulate, escape, or numb intense emotions
  - Provide temporary relief from negative affect

- Binge eating may result in secondary emotions such as shame or guilt
  - These emotions can then prompt further binge eating and purging episodes

Support for Affect Regulation Model in Binge Eating

- Negative mood is most frequently cited precipitant of binge eating (Polivy & Herman, l993)
- Inducing a negative mood (compared to a neutral mood) in the laboratory significantly increased loss of control over eating and the occurrence of self-defined binges in women with BED (Telch & Agras, l996; Agras & Telch, l998)
- Negative mood in association with restrictive dieting in bulimics treated with CBT predicted a lower success rate (by more than 50%) than bulimics who were purely restrictive dieters (Stice & Agras, l999)

Linehan (1993): Dialectical Behavior Therapy (DBT)

Emotional dysregulation seen as core problem in borderline personality disorder (BPD)

Self-destructive impulsive behaviors

Temporary relief from intense emotions

Why "Standard" DBT was Adapted for Eating Disorders

Binge eating → Relief of negative affect in patients who binge eat and/or purge

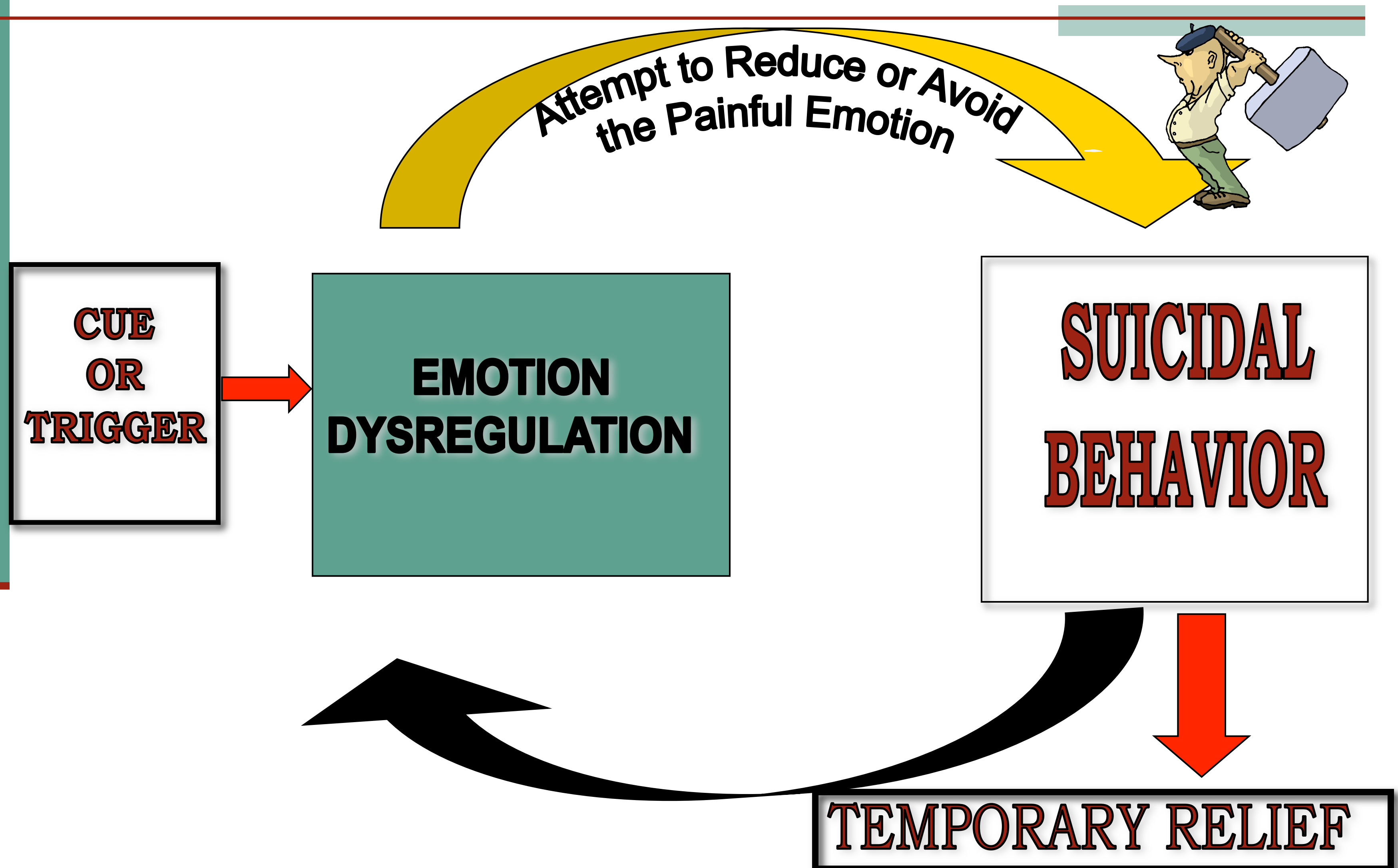
In a Similar Way That

Impulsive Self-Harm Behaviors → Relief of negative affect in BPD

This is the key rationale for adapting DBT to treat patients who binge eat and/or purge

(Mcabe et al. Wisniewski et al., 2003; Telch et al., 1996)

DBT Avoidance Paradigm To Explain Suicidal/ Self-Harm Behaviors



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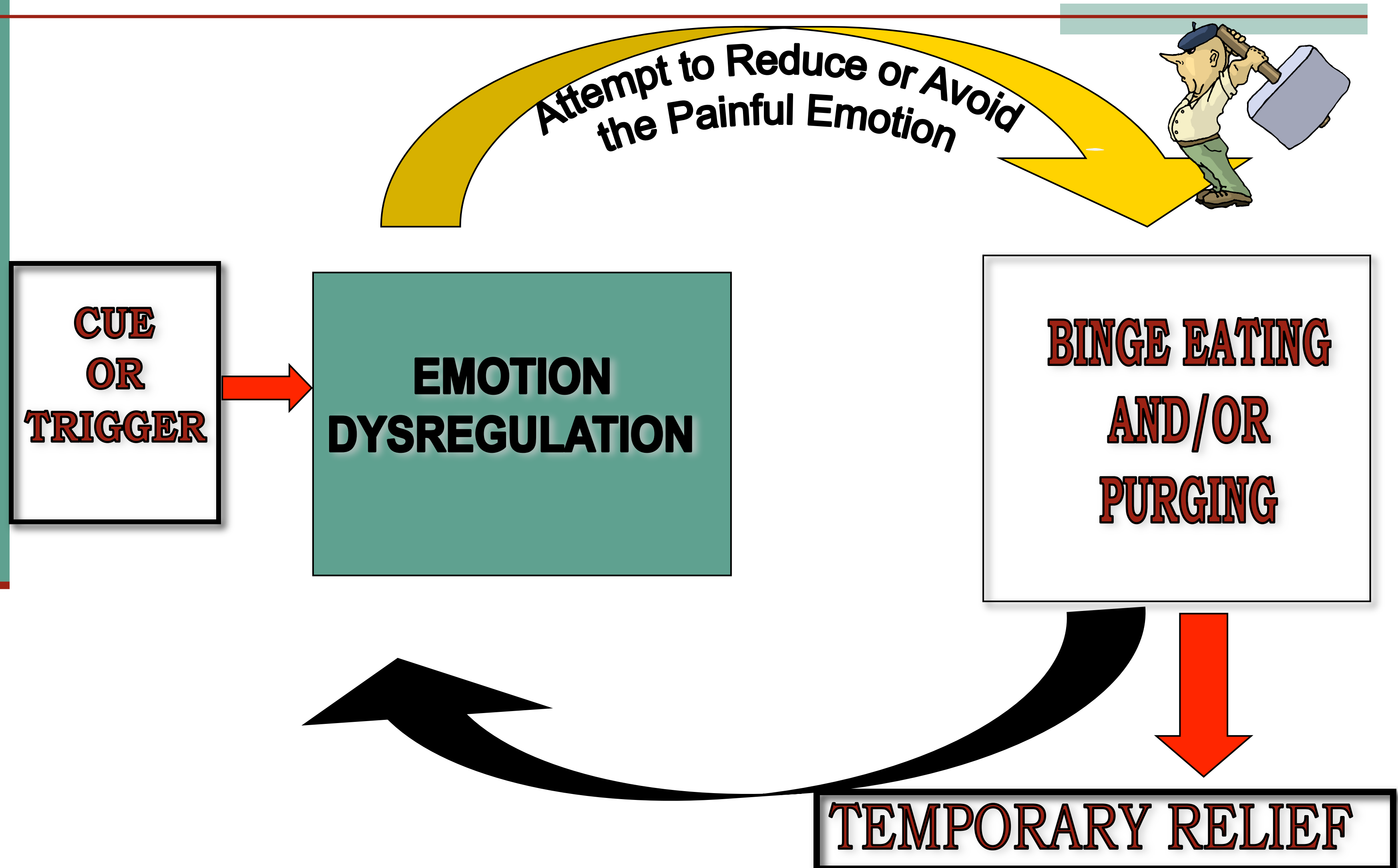

Rationale: Why DBT for EDs?

1. Up to 50% of clients still symptomatic after treatment with standard empirically derived therapies (e.g. CBT, IPT) for BED and BN

- Predictors of poor outcome include co-morbid personality disorders or other Axis I disorders
- Severity of symptoms

Rationale: Why DBT for EDs? (con't)

2. DBT, unlike CBT or IPT, is based on affect regulation model

- Negative affect is most frequent precursor to binge eating (cf. Greeno, Wing, & Shiffman, 2000)
- EDs, like suicidal behaviors, may function to regulate affect
- DBT is specifically designed to teach adaptive affect regulation and to target behaviors resulting from emotional dysregulation

Rationale: Why DBT for EDs? (con't)

3. Many ED patients are ambivalent about their symptoms and treatment
   - DBT's focus on acceptance-based and change-based strategies captures this tension
   - Acceptance focus is equally important for therapists and family members by providing framework for relinquishing control over time course of change
   - DBT involves sophisticated use of commitment strategies

Rationale: Why DBT for EDs? (con't)

4. The Therapist Consultation Team (a component of standard DBT) is particularly useful with ED patients
   - Tendency for ED clients and their symptoms to evoke intense feelings in their providers
   - Consultation team allows therapists to draw upon support of other therapists and expertise of differently trained professionals on the team (e.g. nutritionist, internist)
   - Motivates therapists to stay nonjudgmental

DBT Adapted for Eating Disorders

- Relatively newly adapted treatment for BED and BN
- **DBT-ED premise**: Affect regulation model of Binge Eating and/or purging
  - Binge eating functions (albeit maladaptively) to allow numbing/ avoidance/escape from painful emotional states
- **DBT-ED aim**: Teach *adaptive* emotion regulation skills to replace binge eating and/or purging
- **DBT-ED research findings**: Show initial promise in RCTs (Safer et al., 2001; Safer et al., 2010; Telch et al., 2001;)

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Research Findings

Randomized Controlled Trials for DBT-BED and DBT-BN

- DBT for BN- One RCT to date
  - 31 women randomized to 20 weeks individualized DBT for BN (1 hour/week) or wait-list control

    (Safer, Telch, & Agras, 2001)

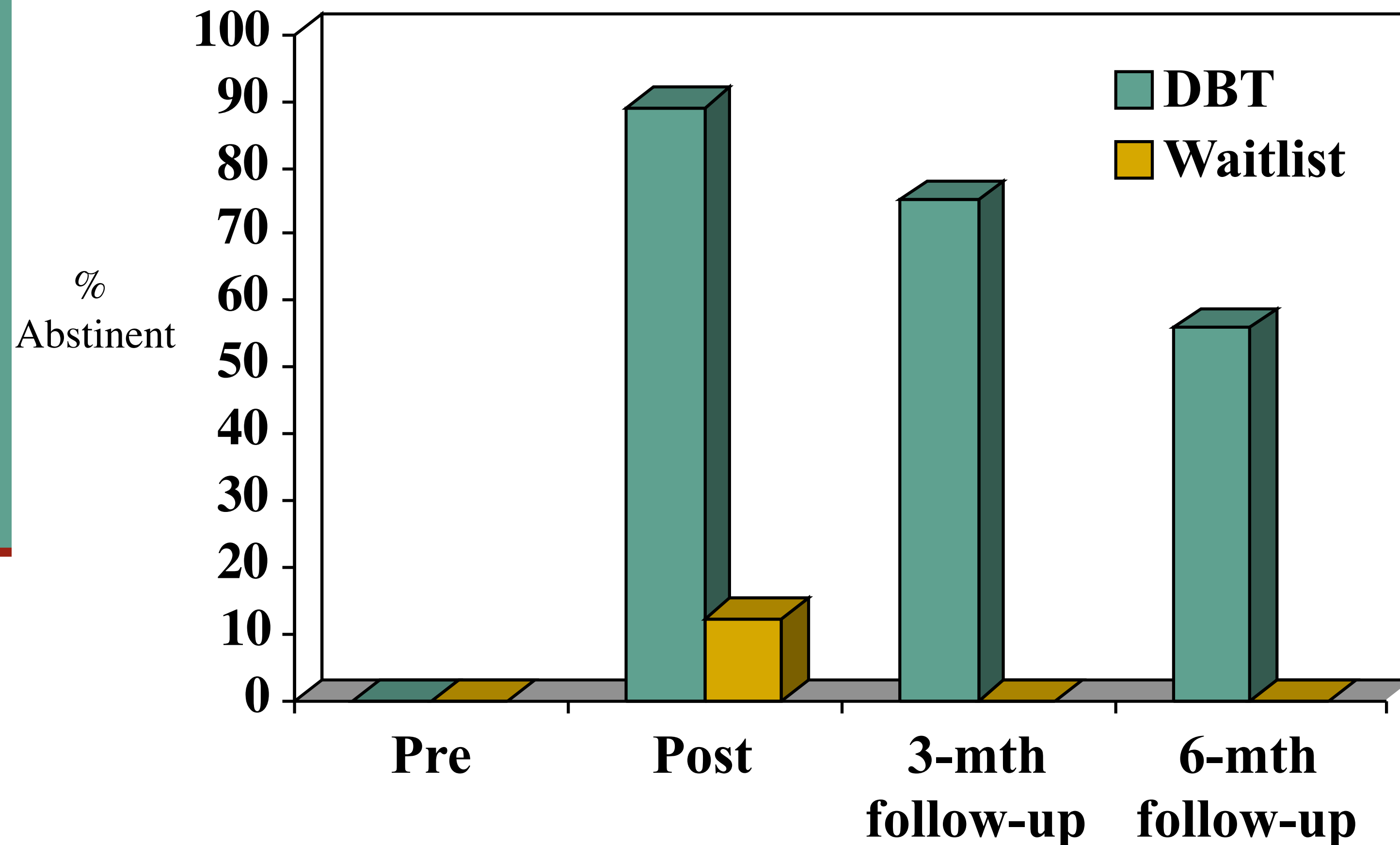
- DBT for BED- Two RCTs to date
  - 44 women randomized to 20 weeks of DBT for BED, group format (2 hours/week) or wait-list control

    (Telch, Agras & Linehan, 2001)
  - 101 men and women randomized to 20 weeks of DBT for BED or an active supportive psychotherapy control.

    (Safer, Robinson, & Jo, 2010)

DBT for BED versus Wait-List: Results of
Randomized Controlled Trial (2001)

Results of Randomized Controlled Trial (2001): Changes in Objective Binge Eating Between DBT and Wait-List



Telch, Agras, & Linehan: Dialectical behavior therapy for binge eating disorder. J of Consult Clin Psychol 2001; 69:1061-1065

Weight Changes Associated with Maintenance of Abstinence (2001)

- Mean weight loss over the initial 20 week course of treatment was 1.9 kg, or 4.2 pounds (SD=12.13) for all participants
- At 6 month follow-up, the 23 (71.9%) participants who maintained abstinence had lost an additional 3.3 kg or 7.2 pounds (SD = 8.6)
- The 9 (28.1%) who relapsed lost an additional 0.7 kg, or 1.5 pounds (SD = 3.0)

(Safer DL, Lively TJ, Telch CF, Agras WS., 2002)

DBT-BED vs. Active Comparison Group Therapy: Results of Randomized Controlled Trial

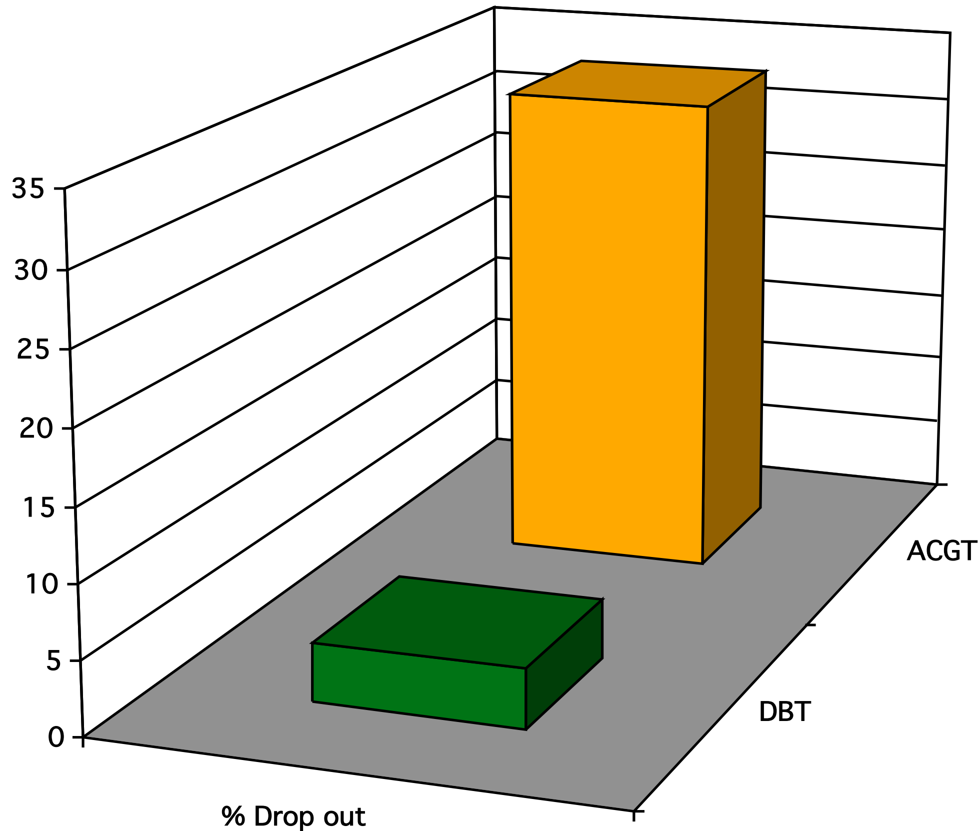
Replication of DBT for BED (2010)

- Larger sample and includes men and women
  - 101 men and women with BED (DSM IV-TR)
  - Men = 15% of sample
- Includes those taking medications if stable X 3 months
  - 32% taking psychotropic medications (e.g., antidepressants)
- Includes an active comparison condition (versus a wait-list control)

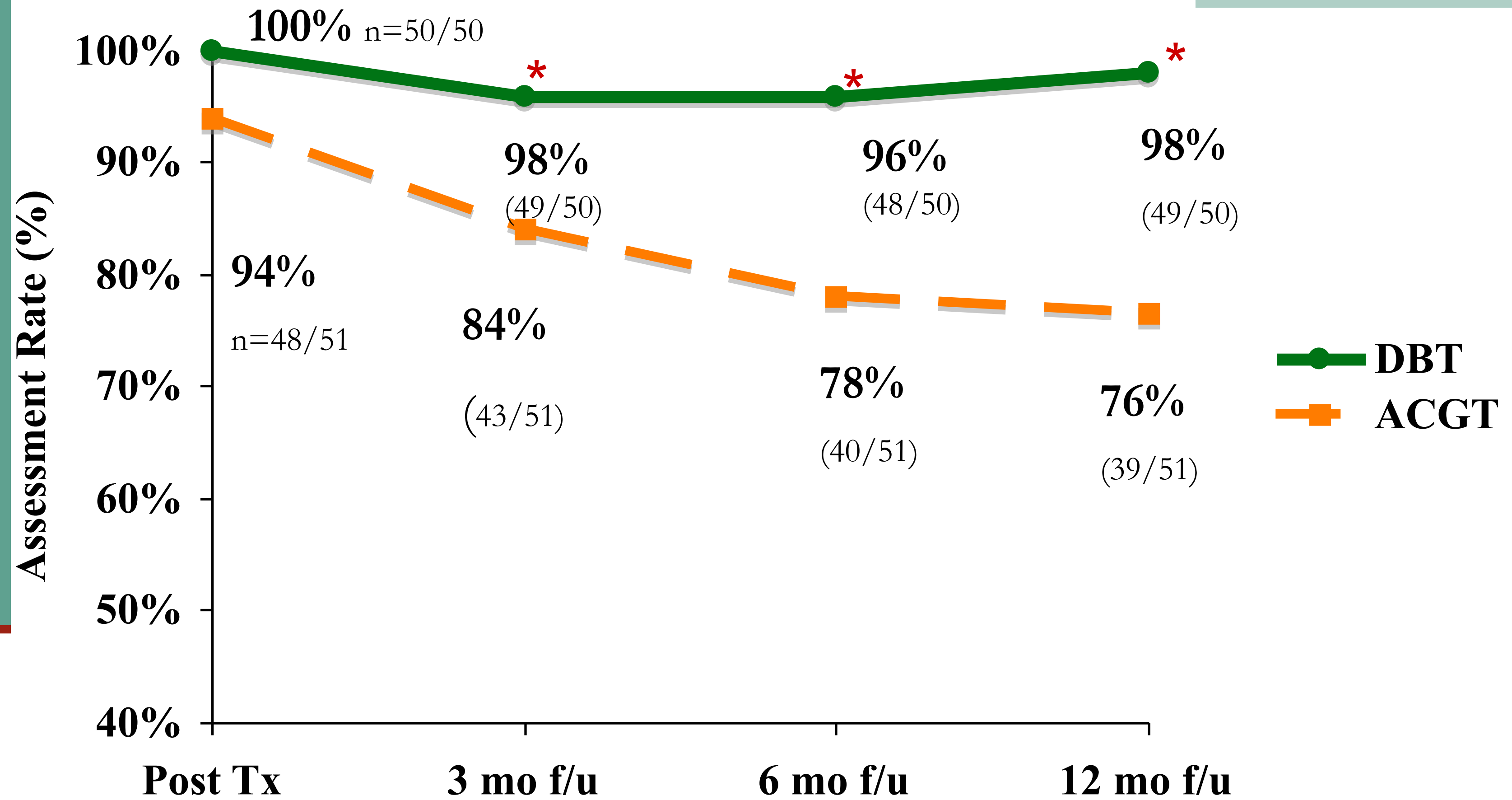
Differential Drop Rates for DBT versus Active Comparison Control

- DBT: 4% drop (2 of 50)
- ACGT: 33.3% drop (17 of 51)

*

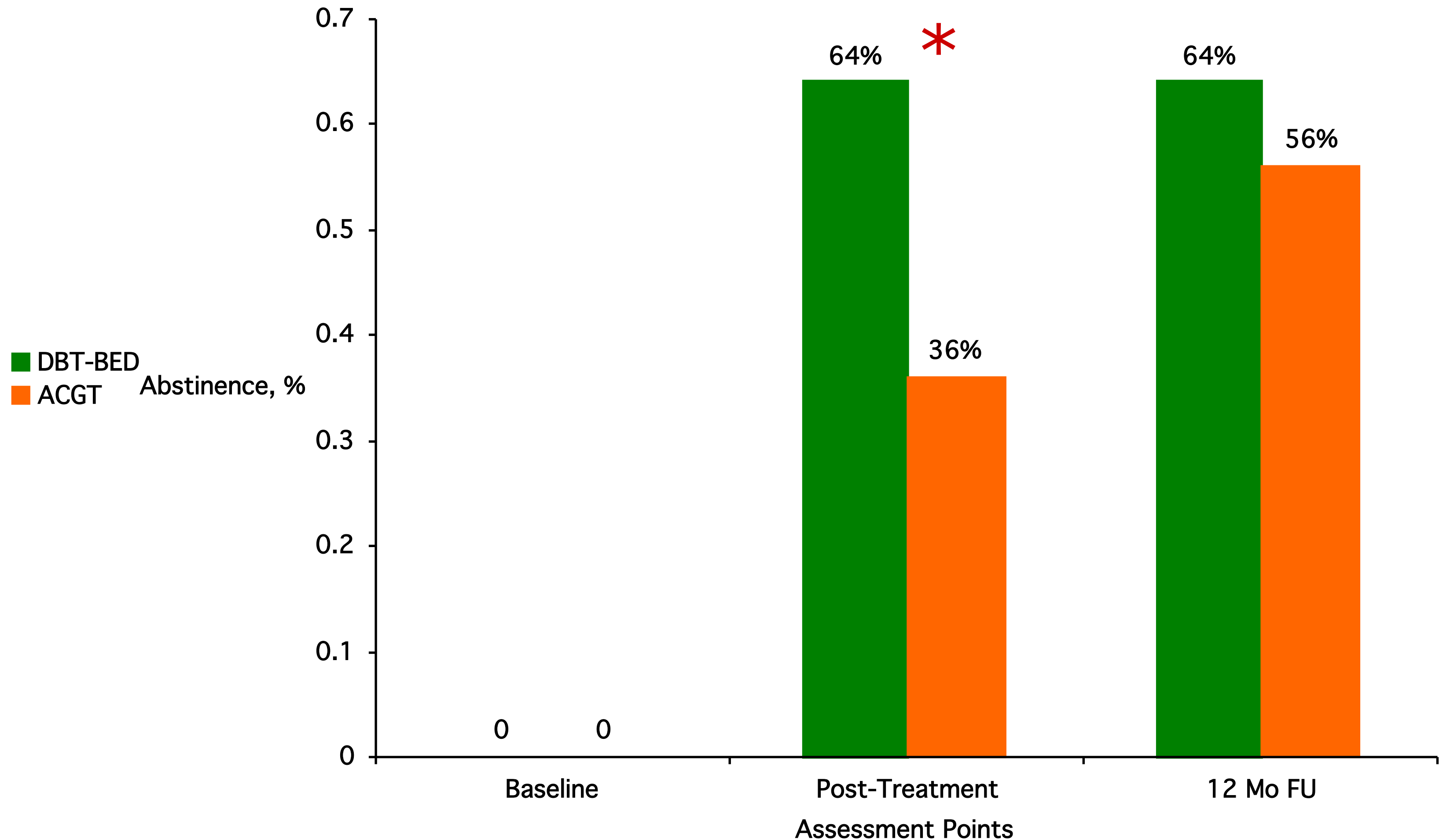


Missing Data Greater in DBT vs. Comparison Control



* p < .05

Research findings (2010): Abstinence Rates for DBT-BED vs. Active Comparison Control



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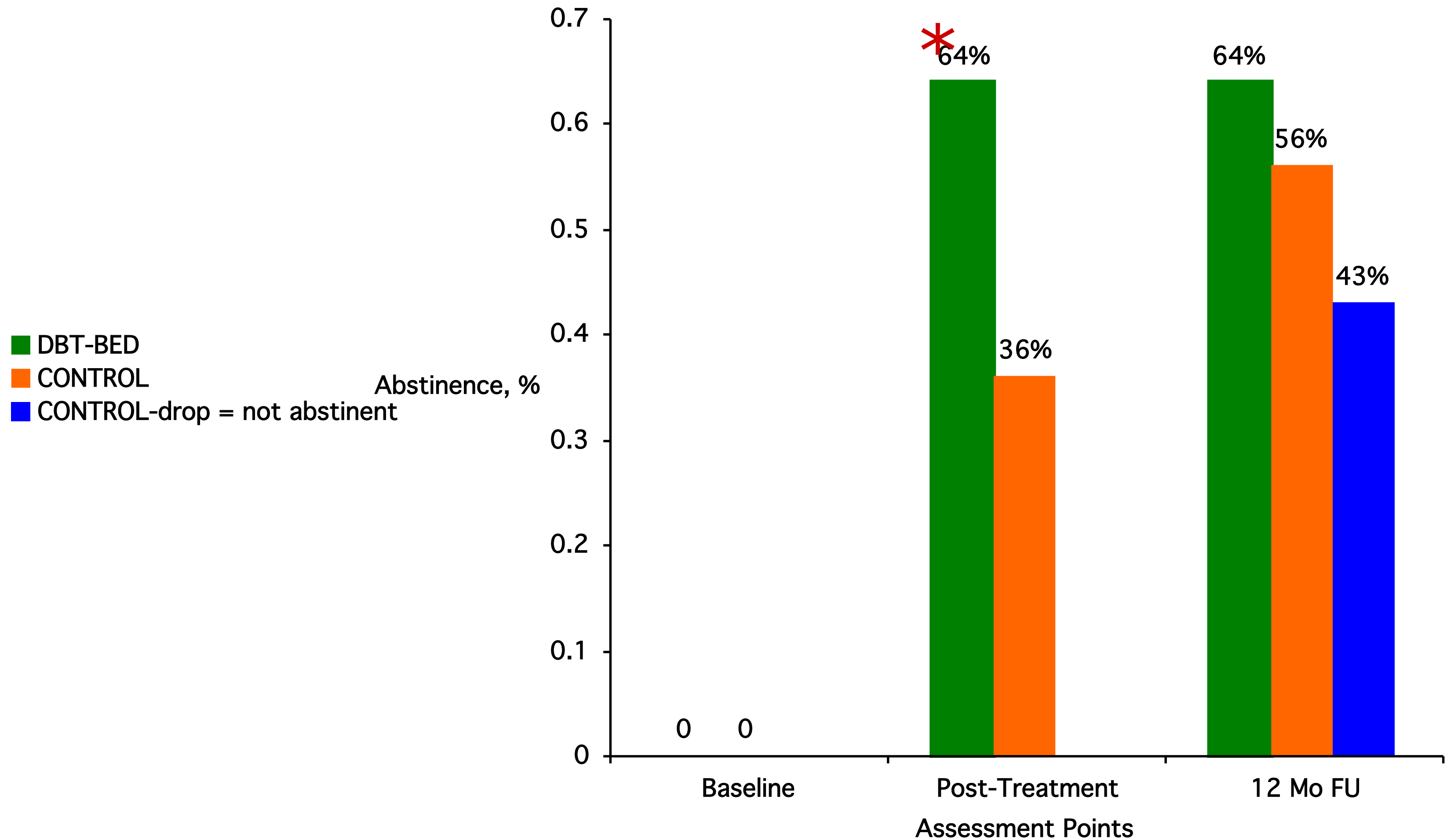
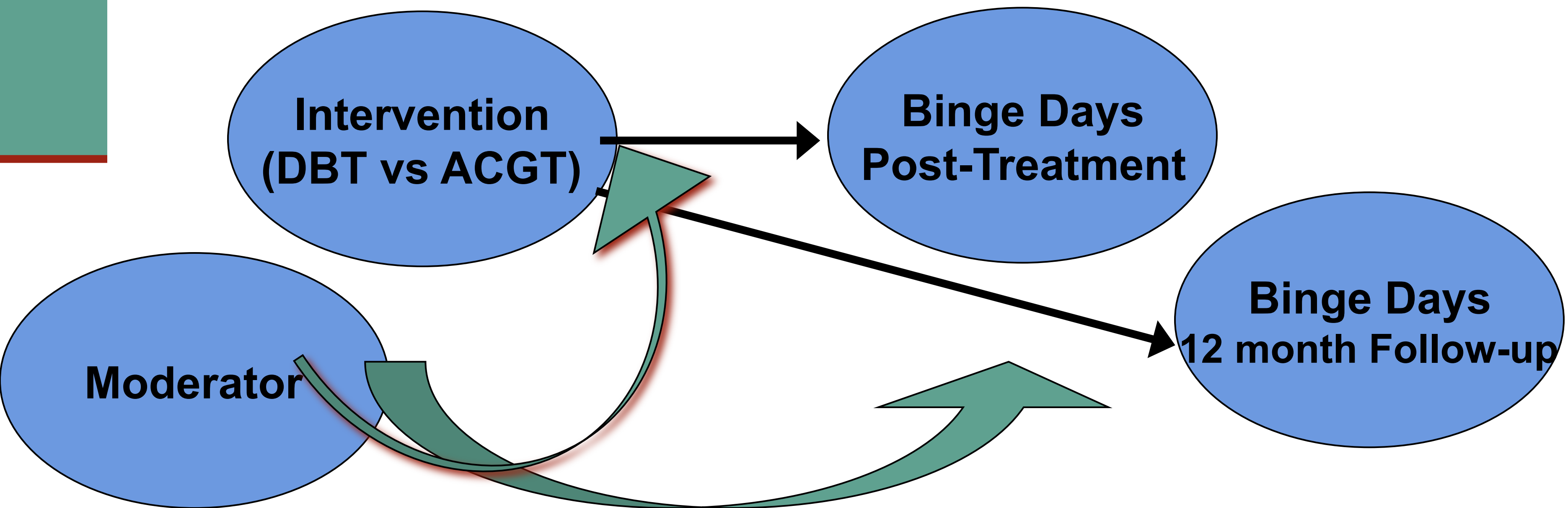


Moderators of Treatment

- Are there certain subgroups of patients for whom or under what conditions a treatment might work better?
- Moderators are pre-randomization or baseline patient characteristics
- Moderators must not be correlated with treatment condition

(i.e., no differences in moderators between groups at baseline)



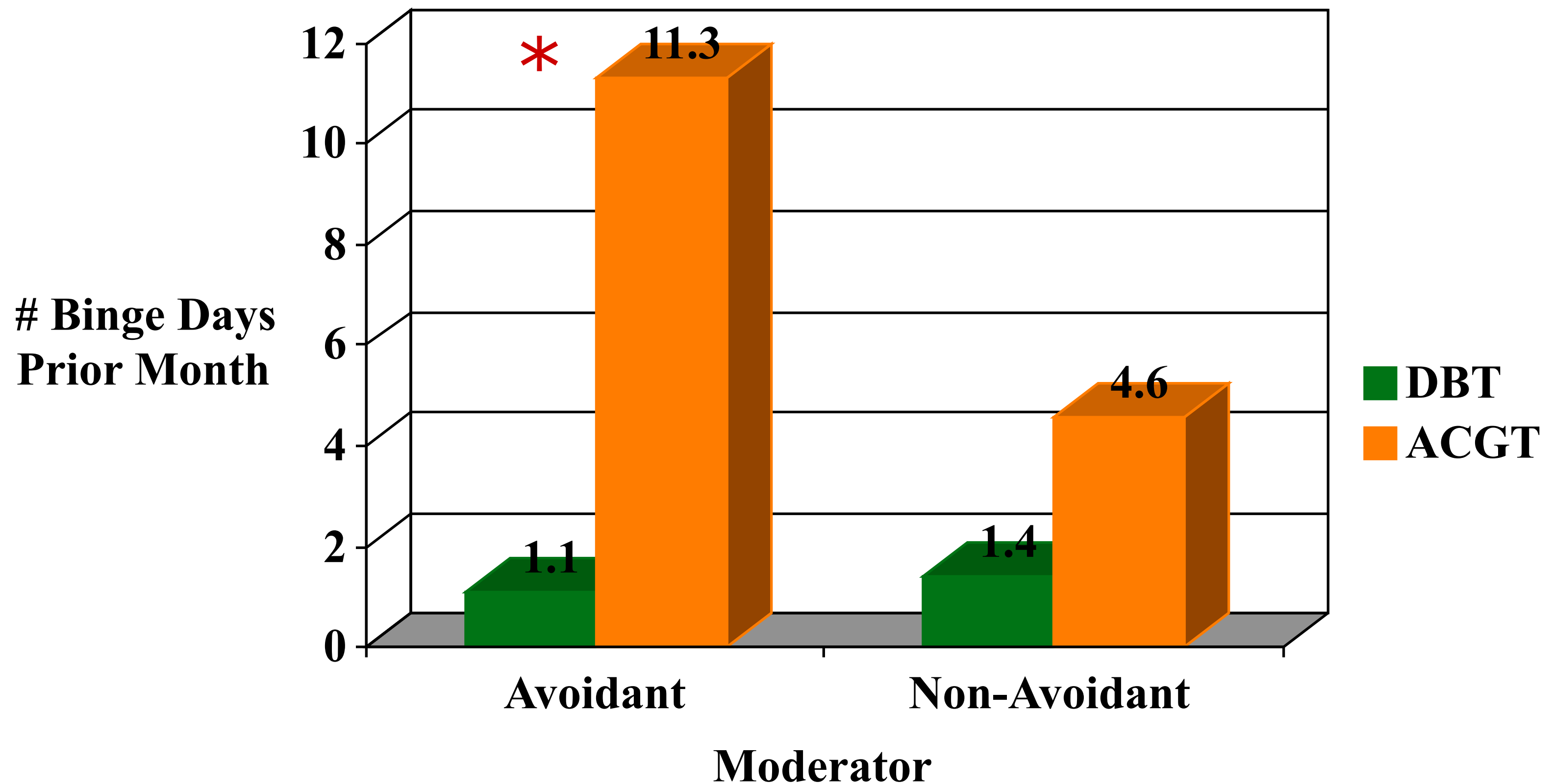
Moderators of Outcome: Subgroups with Better Outcome in DBT for BED versus Control

Patients with

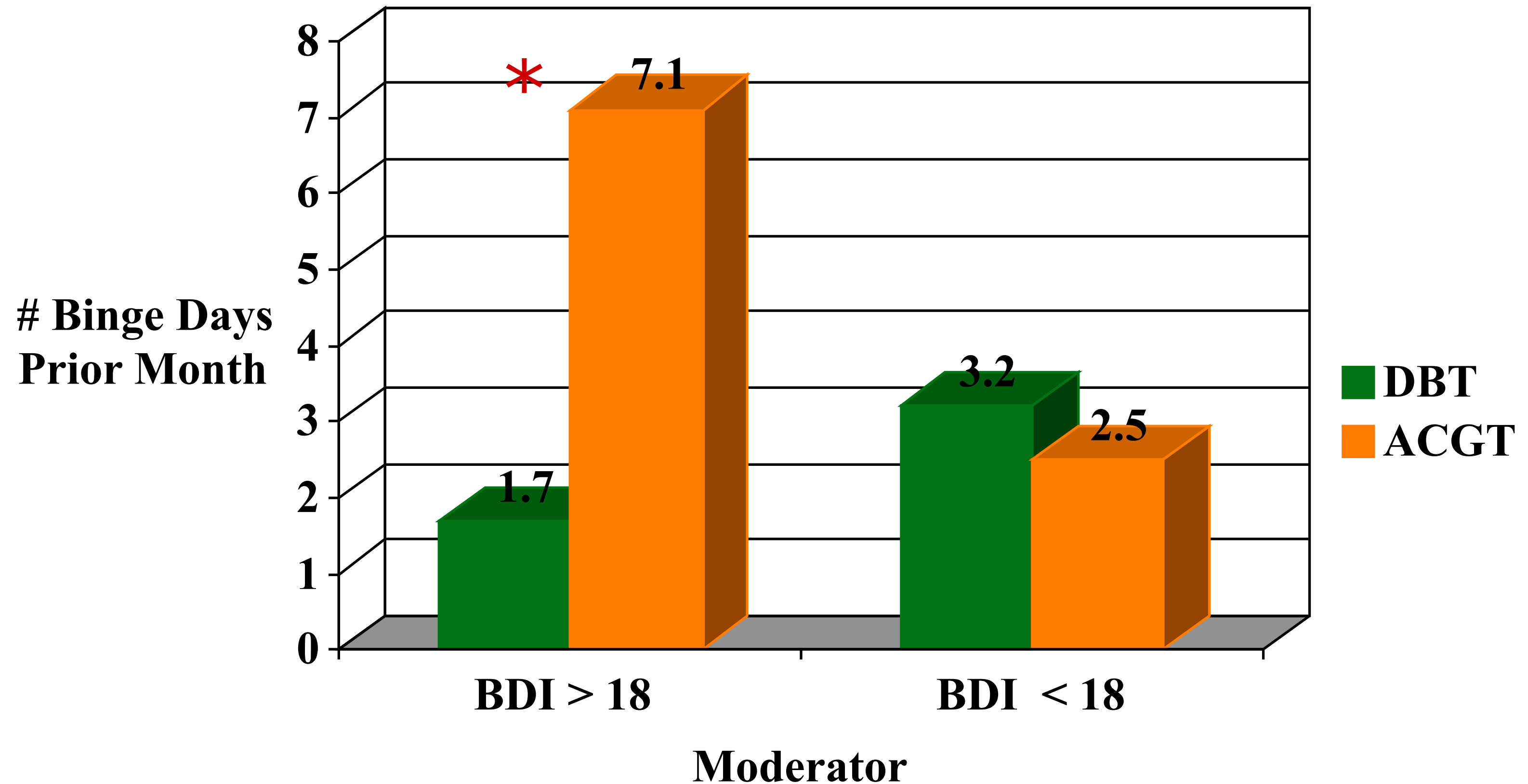
- Avoidant Personality Disorder
- Higher Depression Scores
- More Difficulty Achieving Goals When Emotionally Dysregulated

Have fewer binges at post-treatment and/or 1 year follow-up if randomized to the more specialized treatment, DBT-BED, versus comparison control

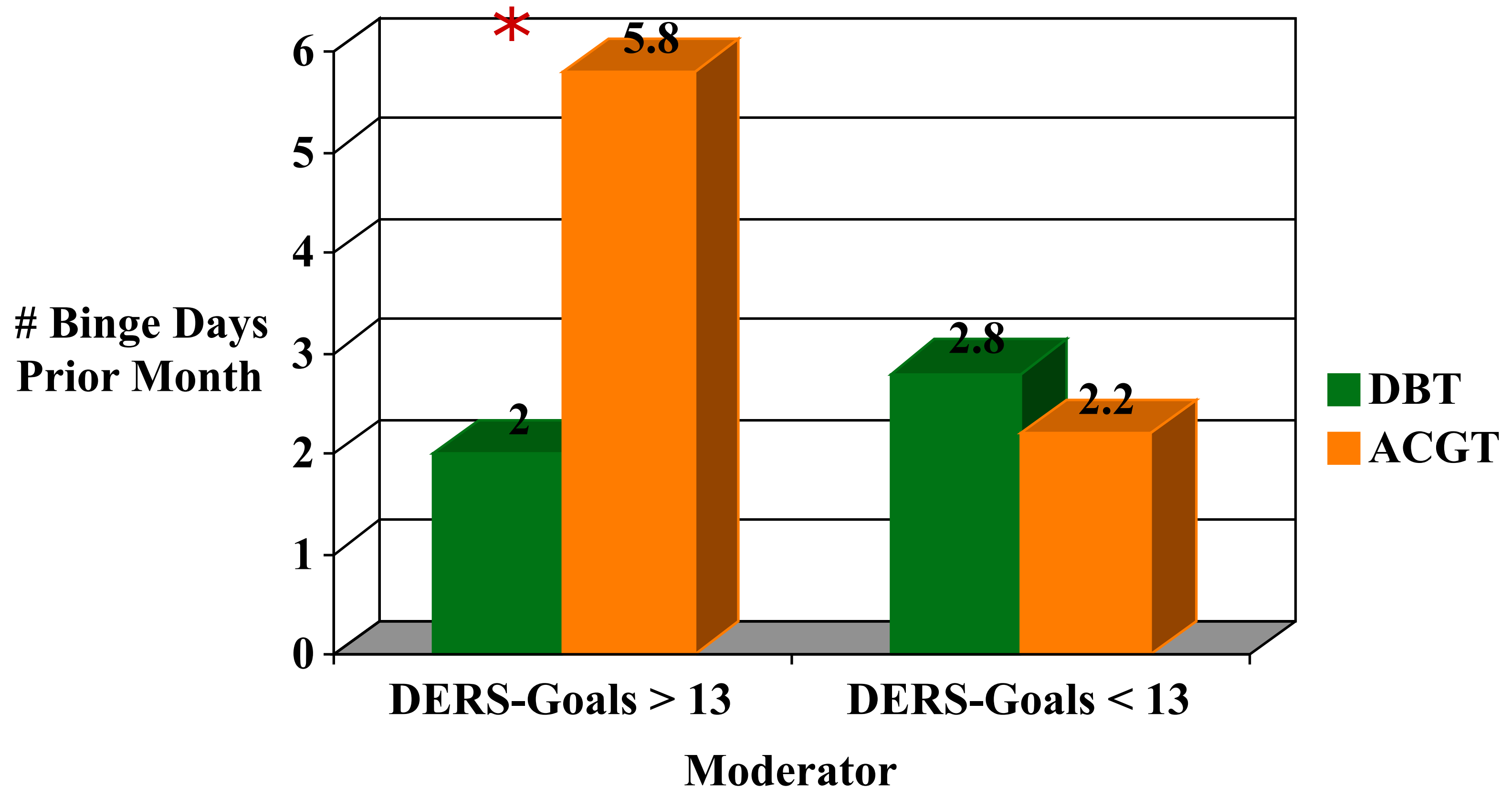
Setting the Stage: Research Findings Patients with Avoidant Personality Disorder Do Better in DBT-BED vs. Active Comparison Control

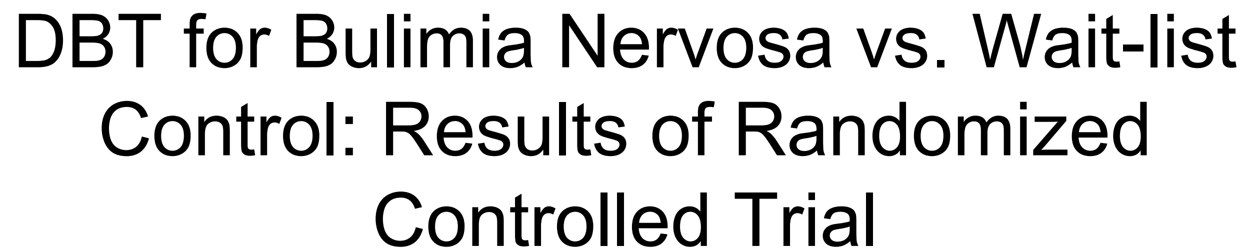


Setting the Stage: Research Findings Patients with Higher Beck Depression Scores (> 18) at Baseline Do Better in DBT-BED vs. Active Comparison Control

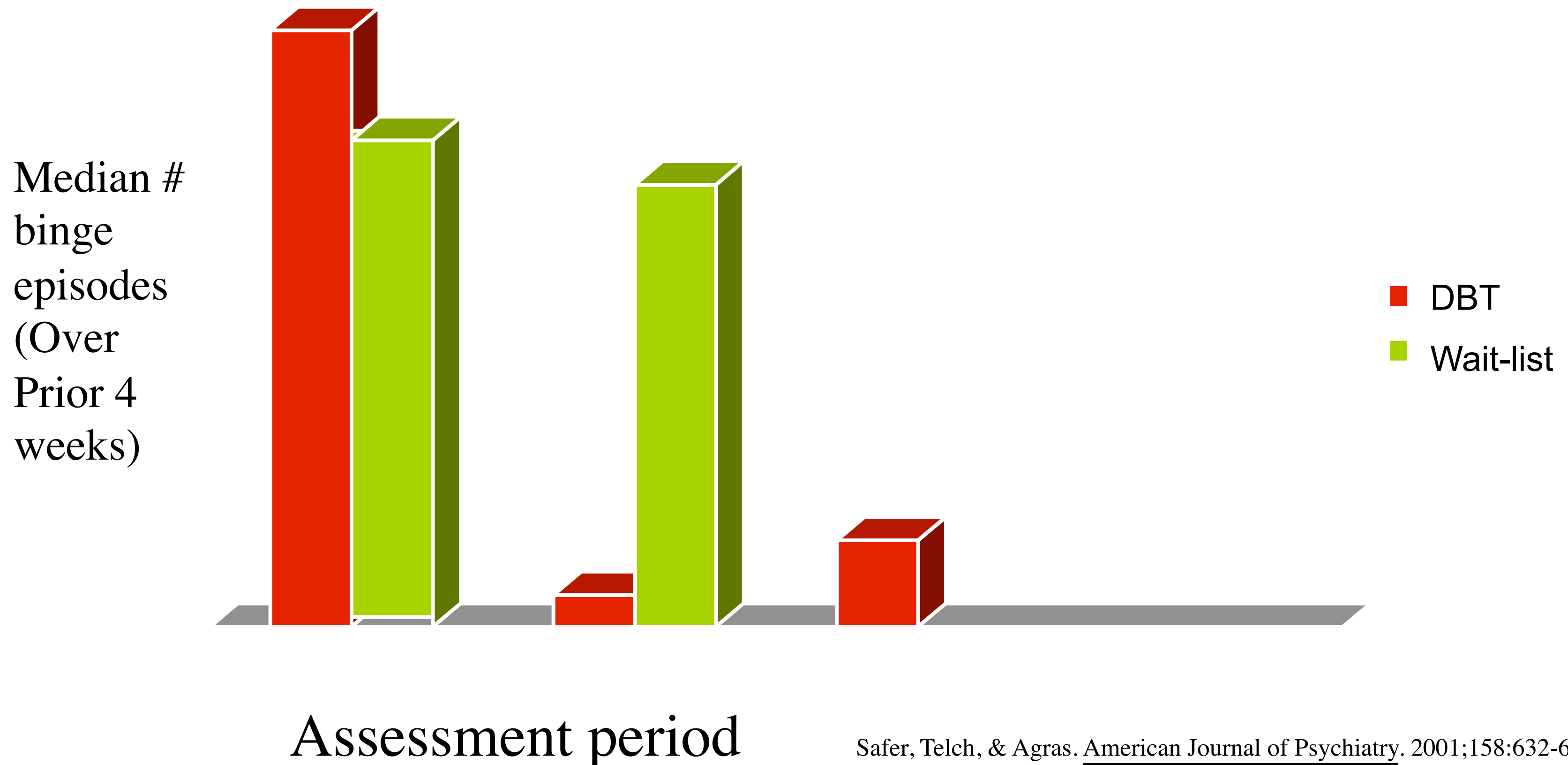


Setting the Stage: Research Findings Patients Who Are More Emotionally Dysregulated at Baseline do better in DBT-BED vs. Active Comparison Control



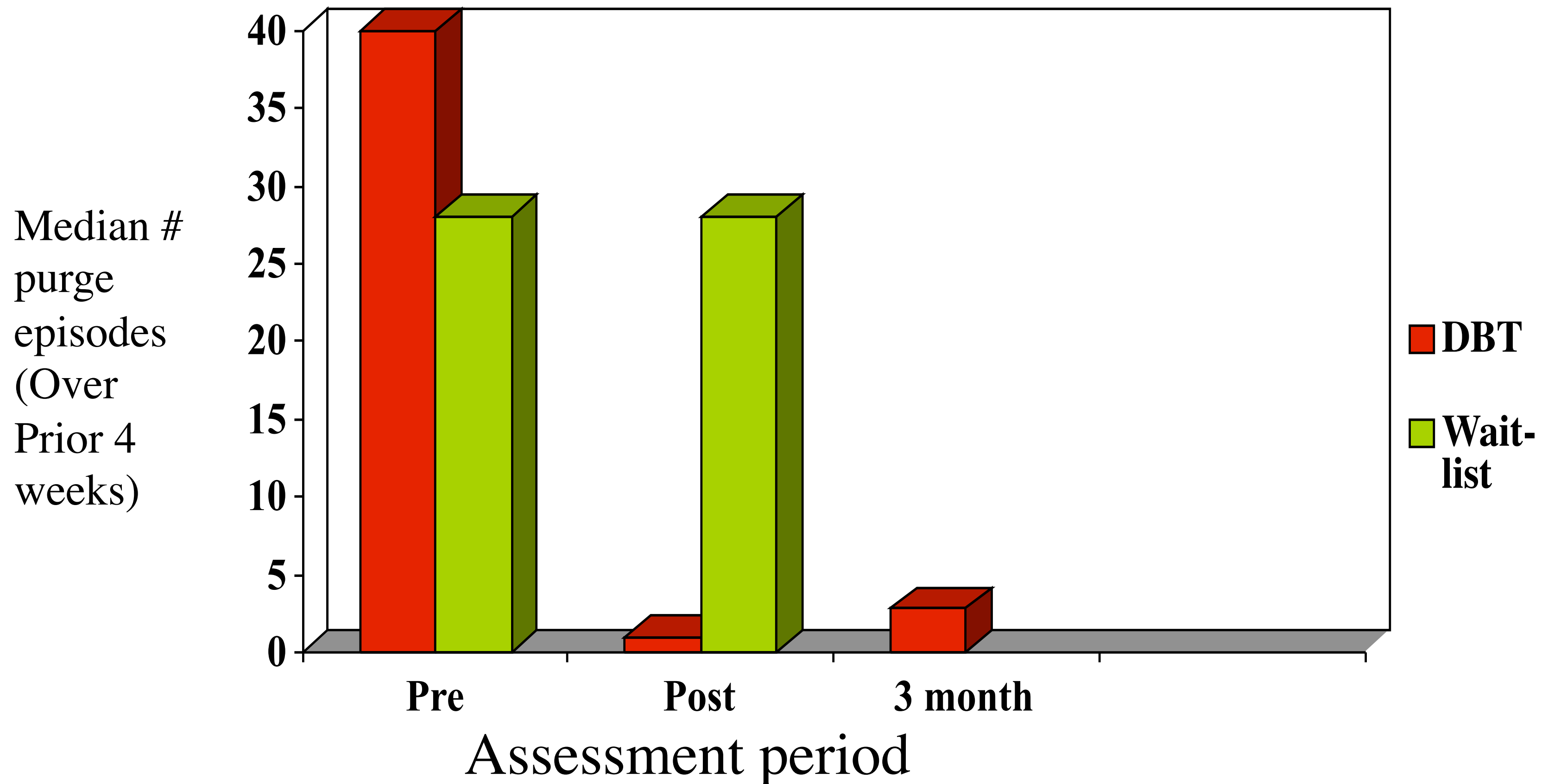

DBT for Bulimia Nervosa vs. Wait-list
Control: Results of Randomized
Controlled Trial

Setting the Stage: Research Findings DBT FOR BN: Significantly Fewer Binge Episodes after DBT-BN Compared to Wait-List ($p < 0.001$)



Safer, Telch, & Agras. American Journal of Psychiatry. 2001;158:632-634.

Setting the Stage: Research Findings DBT FOR BN: Significantly Fewer Purge Episodes after DBT-BN Compared to Wait-List ($p < 0.002$)



Important Caveat: DBT-ED Findings Based on Selected Sample (e.g., Non-Suicidal Patients)

Exclusion Criteria:

- Current Suicidality
- Current Substance abuse/dependence
- Psychosis
- Concurrent psychotherapy or weight loss treatment
- Use of any psychiatric medications (Telch et al., 2001) or unstable 3 month med regime (Safer et al., 2010)
- Medical illness affecting weight/shape (e.g., insulin dependent diabetes)

Note: While borderline personality was not an exclusion factor, few met full criteria for BPD (Telch et al., 2001- 0% and Safer et al., 2010-3%)

What Types Of Clients Might Most Benefit From Receiving This Treatment?

Most conservative recommendation at this time

- DBT as adapted for binge eating and bulimic behavior most appropriate for clients who have failed to improve or received minimal benefit after standard, evidence based eating disorder treatments (e.g.,CBT, IPT)
- For a patient with severe bulimia who is clearly restricting, CBT would be the first choice for treatment
- However, in our treatment clinic, if the patient is not very severe and is not highly restrictive, we may explain the 3 models to the patient.
  - Together, patient and therapist would choose the model that seems to fit best.
  - Often, DBT is chosen

When NOT to use DBT for Binge Eating/Purging

- With BED or BN clients with:
  - Severely chronic multiple symptoms
  - Active suicidality
  - Combined borderline personality disorder and active substance abuse/dependence

- The ORIGINAL comprehensive multimodal DBT program would be the treatment of choice for such clients

Outline

- **Section 1**: Setting the stage: Why apply DBT for Eating Disorders?
- **Section 2**: Pretreatment and Skills Modules: Commitment and Orientation to the Model (Session 1-2)
- **Section 3**: Application of the Skills within an Adapted 3 Module Program (Sessions 3-18)
- **Section 4**: Relapse prevention, case illustration & discussion (Session 19-20)

Outline

- **Section 1**: Setting the stage: Why apply DBT for Eating Disorders?

Section 2. Pretreatment and Early Sessions (1& 2):

1. Brief Introduction to DBT
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Outline

Section 2. Pretreatment and Early Sessions (1& 2):

1. Brief Introduction to DBT

A. Similarities and Differences Between "Standard" DBT and Adapted DBT for BED and BN

- Treatment Structure
- Theoretical Foundation
- Core DBT Strategies
  - Core Behavioral Analysis Strategies
  - Core Solution Analysis Strategies: ED-specific Concepts and Skills
  - Dialectical Strategies
- 2. Commitment and Orientation to the Model

Outline

Section 2. Pretreatment and Early Sessions (1& 2):

1. Brief Introduction to DBT

A. Similarities and Differences Between "Standard" DBT and Adapted DBT for BED and BN

- Treatment Structure
- Theoretical Foundation
  - DBT core theories
  - Biosocial model
    - Extending notion of Biological and Invalidating Environment
  - Core DBT Strategies
    - Core Behavioral Analysis Strategies
    - Core Solution Analysis Strategies: ED-specific Concepts and Skills
    - Dialectical Strategies

2. Commitment and Orientation to the Model

Similarities and Differences Between "Standard" DBT and Adapted DBT for BED and BN

Structure of Treatment

- DBT adapted for BED and BN has a unique structure
- Combines aspects of "Standard" DBT Individual and Group Skills Training combined into SINGLE weekly session
    - (e.g., 1-hour individual session or 2-hour group session)
  - First half
    - Review Diary Cards, Chain analyses, Skills homework
  - Second half
    - Instruction on New Skills
    - Pre-Treatment Orientation Session (20-30 minutes)

Treatment Structure: Three (Not Four) Skills Modules

- Mindfulness module
- Emotion Regulation module
- Distress Tolerance module

- Interpersonal Effectiveness module omitted
  - Research-related Rationale
    - Time limit of only 20 sessions
      - CBT and IPT for BED effective within 20 2-hour sessions
  - Theoretical overlap of Interpersonal Effectiveness module and IPT

- In non-research setting: No reason to omit Interpersonal Effectiveness module

Treatment Structure: Outline of 20 DBT for BED & BN Weekly Sessions

PRE-TREATMENT ORIENTATION: Meet with each group member individually to orient to model (20-30 Minutes)

INTRODUCTION (Sessions 1-2): Introductions, Orientation to model and treatment targets, Group rules and agreements, Commitment strategies

MINDFULNESS SKILLS (Sessions 3-5): Increase awareness and experience of the current moment without self-consciousness or judgment

EMOTION REGULATION SKILLS (Sessions 6-13): Help participant identify emotions, understand their function, reduce vulnerability to negative emotions & increase positive emotions

DISTRESS TOLERANCE SKILLS (Sessions 14-18): Crisis Survival skills (e.g. distraction) and acceptance skills to help tolerate distressing emotional states that cannot, in that moment, be changed.

REVIEW & RELAPSE STRATEGIES (Sessions 19-20)

Similarities and Differences Between "Standard" DBT and Adapted DBT for EDs

- **Treatment Structure**
- **Theoretical Foundation**:
  - DBT core theories
  - Biosocial model
    - Extending notion of Biological and Invalidating Environment
- **Core DBT Strategies:**
  - Core Behavioral Analysis Strategies
    - ED-Specific Treatment Targets/Therapy-Interfering Behaviors
    - Monitoring and analysis of Problem Behaviors
      - ED-Specific Chain Analysis
      - ED-specific Diary Card
  - Core Solution Analysis Strategies: ED-specific Concepts and Skills
      - *Pre-Commitment: Eliciting Commitment to Stop Binge Eating*
      - *Mindfulness: Mindful Eating, Urge Surfing, Alternate Rebellion*
      - *Emotion Regulation*
      - *Distress Tolerance: Burning Bridges*
      - *Relapse Prevention: Coping Ahead*
  - Dialectical Strategies

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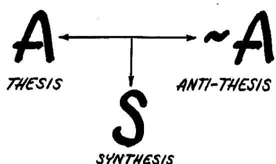
      - *Mindfulness: Mindful Eating, Urge Surfing, Alternate Rebellion*
      - *Emotion Regulation*
      - *Distress Tolerance: Burning Bridges*
      - *Relapse Prevention: Coping Ahead*
  - Dialectical Strategies
    - Dialectical Abstinence

DBT Core Theories



Dialectical Theory

Behavioral Science

Mindfulness/ Zen Practice

(Linehan, 1993)

A Dialectical Approach Involves Balancing:

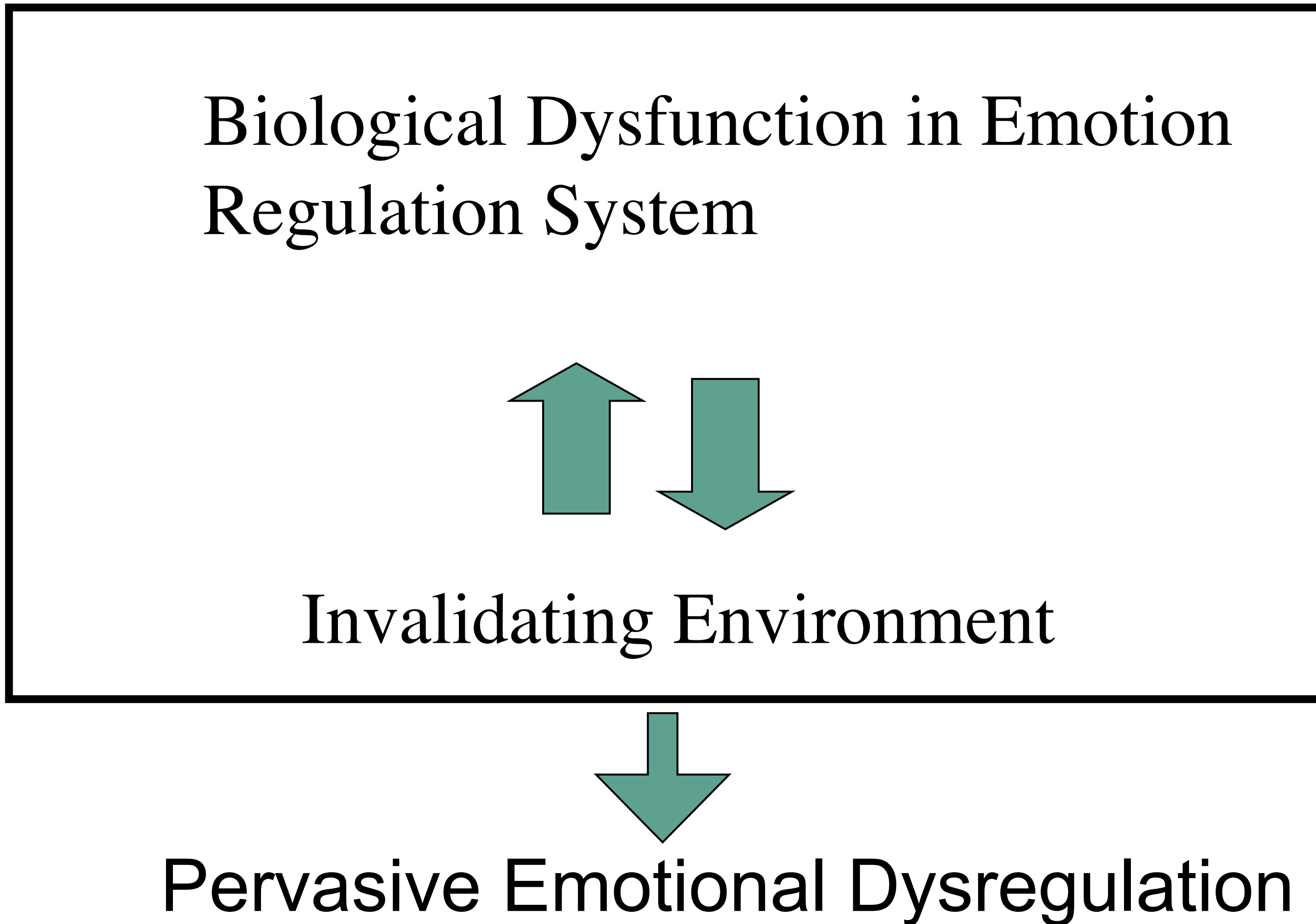
Change
Problem Solving

Acceptance
Validation

Similarities and Differences Between "Standard" DBT and Adapted DBT for EDs

- **Theoretical Foundation**:
  - DBT core theories
  - Biosocial model
    - Extending notion of Biological and Invalidating Environment
- **Basic DBT Strategies:**
  - Core Behavioral Analysis Strategies
    - ED-Specific Treatment Targets/Therapy-Interfering Behaviors
    - Monitoring and analysis of Problem Behaviors
      - ED-Specific Chain Analysis
      - ED-specific Diary Card
  - Core Solution Analysis Strategies: ED-specific Concepts and Skills
      - *Pre-Commitment: Eliciting Commitment to Stop Binge Eating*
      - *Mindfulness: Mindful Eating, Urge Surfing, Alternate Rebellion*
      - *Emotion Regulation*
      - *Distress Tolerance: Burning Bridges*
      - *Relapse Prevention: Coping Ahead*
  - Dialectical Strategies
    - Dialectical Abstinence

DBT Biosocial Model of Borderline Personality Disorder



Biosocial Model: Biologically-Based Emotional Vulnerability

- **High Sensitivity**
  - Immediate reactions
  - Low threshold for emotional reaction
- **High Reactivity**
  - Extreme reactions
  - High arousal dysregulates cognitive processing
- **Slow return to baseline**
  - Long-lasting reactions
  - Contributes to high sensitivity to next emotional stimulus

Biosocial Model: Invalidating Environment

- Self-generated behaviors and communication of private experiences are rejected as invalid
  - Goldfish example
- Emotional displays and/or pain behaviors met by punishment and escalation met by erratic, intermittent reinforcement
- Ease of problem solving and meeting goals is oversimplified
  - "Smile"
  - "Pull yourself up by your bootstraps"
  - "If you want fish, you must get wet."

Biosocial Model: Consequences of Invalidating Environment

- Because of invalidation, person is NOT taught to:
  - Trust experiences as valid responses to events
  - Effectively regulate emotions
- By punishing and intermittently reinforcing, NOT taught to:
  - Communicate emotional pain effectively
- Because of oversimplifying, NOT taught to:
  - Tolerate distress
  - Solve difficult problems in living
- Instead, person is taught to form unrealistic goals
  - Consequently becomes highly distressed by failure

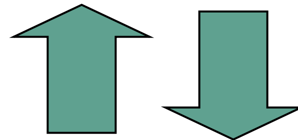
Similarities and Differences Between "Standard" DBT and Adapted DBT for EDs

- **Treatment Structure**
- **Theoretical Foundation**:
  - DBT core theories
  - Biosocial model
    - Extending notion of Biological and Invalidating Environment
- **Core DBT Strategies:**
  - Core Behavioral Analysis Strategies
    - ED-Specific Treatment Targets/Therapy-Interfering Behaviors
    - Monitoring and analysis of Problem Behaviors
      - ED-Specific Chain Analysis
      - ED-specific Diary Card
  - Core Solution Analysis Strategies: ED-specific Concepts and Skills
      - *Pre-Commitment: Eliciting Commitment to Stop Binge Eating*
      - *Mindfulness: Mindful Eating, Urge Surfing, Alternate Rebellion*
      - *Emotion Regulation*
      - *Distress Tolerance: Burning Bridges*
      - *Relapse Prevention: Coping Ahead*
  - Dialectical Strategies
    - Dialectical Abstinence

Extending Notion of Biosocial Model

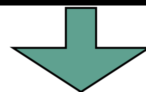
Biological Dysfunction

Nutritional Vulnerability



Invalidating Environment

Invalidation via Mixed Media Messages
(Recipes for Desserts vs. Be Thin)
Weight related-teasing
Invalidation by Western cultural expectations
for beauty ("Thin= Success")



Pervasive Emotional Dysregulation

Similarities and Differences Between "Standard" DBT and Adapted DBT for EDs

- **Treatment Structure**
- **Theoretical Foundation**:
  - DBT core theories
  - Biosocial model
    - Extending notion of Invalidating Environment
- **Core DBT Strategies:**
  - Core Behavioral Analysis Strategies
    - ED-Specific Treatment Targets/Therapy-Interfering Behaviors
    - Monitoring and analysis of Problem Behaviors
      - ED-Specific Chain Analysis
      - ED-specific Diary Card
  - Core Solution Analysis Strategies: ED-specific Concepts and Skills
      - *Pre-Commitment: Eliciting Commitment to Stop Binge Eating +/- Bulimia*
      - *Mindfulness: Mindful Eating, Urge Surfing, Alternate Rebellion*
      - *Emotion Regulation*
      - *Distress Tolerance: Burning Bridges*
      - *Relapse Prevention: Coping Ahead*
  - Dialectical Strategies
    - Dialectical Abstinence

Similarities and Differences Between "Standard" DBT and Adapted DBT for EDs

- **Treatment Structure**
- **Theoretical Foundation**:
  - DBT core theories
  - Biosocial model
  - Extending notion of Invalidating Environment
- **Core DBT Strategies:**
  - Core Behavioral Analysis Strategies
    - ED-Specific Treatment Targets/Therapy-Interfering Behaviors
    - Monitoring and analysis of Problem Behaviors
      - ED-Specific Chain Analysis
      - ED-specific Diary Card
  - Core Solution Analysis Strategies: ED-specific Concepts and Skills
      - *Pre-Commitment: Eliciting Commitment to Stop Binge Eating*
      - *Mindfulness: Mindful Eating, Urge Surfing, Alternate Rebellion*
      - *Emotion Regulation*
      - *Distress Tolerance: Burning Bridges*
      - *Relapse Prevention: Coping Ahead*
  - Dialectical Strategies
    - Dialectical Abstinence

Similarities and Differences Between "Standard" DBT and Adapted DBT for EDs: Core DBT Strategies

- **Behavioral Analysis Strategies**
  - ED-Specific Treatment Targets/Therapy-Interfering Behaviors
  - Monitoring and analysis of Problem Behaviors
    - ED-Specific Chain Analysis
    - ED-specific Diary Card
- **Solution Analysis strategies**
  - Skills Training
    - Skills acquisition, strengthening, generalization
- **Dialectical Strategies**
  - Balance Problem Solving with Acceptance

Similarities and Differences Between "Standard" DBT and Adapted DBT for EDs: Core DBT Strategies

- **Behavioral Analysis Strategies**
  - ED-Specific Treatment Targets/Therapy-Interfering Behaviors
  - Monitoring and analysis of Problem Behaviors
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- **Solution Analysis strategies**
  - Skills Training
    - Skills acquisition, strengthening, generalization
- **Dialectical Strategies**
  - Balance Problem Solving with Acceptance

Standard DBT Standard DBT Treatment Targets

Overall Treatment Goal: **Decrease Problem Behaviors (e.g., suicidal behavior, self-harm)**

First Stage Treatment Targets:

1. **Stop/decrease any Life Interfering Behavior**
2. **Stop/decrease any therapy interfering behaviors**
3. **Stop/decrease any Quality of Life Interfering Behaviors**
4. **Increase Skillful Emotion Regulation Behaviors**
   - **A. Core Mindfulness Skill**
   - **B. Emotion Regulation**
   - **C. Distress Tolerance**
   - **D. Interpersonal Effectiveness**

Adapting DBT for Eating Disorders: Treatment Targets

Treatment Goals: Stop Problematic Eating Behaviors

Treatment Targets:

1. **Stop any Life Interfering Behavior**
2. **Stop any behavior that interferes with treatment**
3. **Stop or decrease any Quality of Life Interfering Behavio**

   Path to Mindful Eating

   A. **Stop Binge Eating and/or Purging**
   B. **Eliminate Mindless Eating**
   C. **Decrease Cravings, Urges, Preoccupation with food**
   D. **Decrease "Capitulating" (i.e., closing off options to not binge eat and/or purge**
   E. **Decrease "Apparently Irrelevant Behaviors"**
4. **Increase Skillful Emotion Regulation Behaviors**

Adapting DBT for Eating Disorders: Treatment Targets

Treatment Goals: **Stop Problematic Eating Behaviors**

Treatment Targets:

1. **Stop any Life Interfering Behavior**
2. **Stop any behavior that interferes with treatment**
3. **Stop or decrease any Quality of Life Interfering Behavior**

Path to Mindful Eating

A. **Stop Binge Eating and/or Purging**
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E. **Decrease "Apparently Irrelevant Behaviors"**

4. Increase Skillful Emotion Regulation Behaviors

ED-Specific Goals Treatment Targets

Treatment Targets:

[1] ***Stop any Life Interfering Behavior***

- Always holds true but less characteristic of population for whom DBT-BED/BN designed

1. Stop any behavior that interferes with treatment

2. Stop or decrease any Quality of Life Interfering Behaviors

   Path to Mindful Eating

   A. Stop Binge Eating and/or Purging
   B. Eliminate Mindless Eating
   C. Decrease Cravings, Urges, Preoccupation with food
   D. Decrease "Capitulating" (i.e., closing off options to not binge eat and/or purge
   E. Decrease "Apparently Irrelevant Behaviors"

1. Stop any behavior that interferes with treatment

2. Stop or decrease any Quality of Life Interfering Behaviors

Path to Mindful Eating

A. Stop Binge Eating and/or Purging
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1. Stop any behavior that interferes with treatment

2. Stop or decrease any Quality of Life Interfering Behaviors

Path to Mindful Eating

A. Stop Binge Eating and/or Purging
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D. Decrease "Capitulating" (i.e., closing off options to not binge and/or purge
E. Decrease "Apparently Irrelevant Behaviors"

Mindless Eating

- Refers to not paying attention to what you are eating
- Do not experience the sense of loss of control of binge episodes
- Example:
  - Sitting in front of the TV and eating a bag of microwave popcorn or chips without any awareness of the eating
  - "Suddenly notice" food is gone and only vaguely aware of having eaten it
  - Did not feel a sense of being out of control during the eating episode

1. Stop any behavior that interferes with treatment

2. Stop or decrease any Quality of Life Interfering Behaviors

<u>Path to Mindful Eating</u>

A. Stop Binge Eating and/or Purging
B. Eliminate Mindless Eating
C. Decrease Cravings, Urges, Preoccupation with food
D. Decrease "Capitulating" (i.e., closing off options to not binge and/or purge
E. Decrease "Apparently Irrelevant Behaviors"

Decrease Cravings, Urges, Preoccupation with Food

- Attention absorbed or focused on food- “Can’t turn it off”
- Function of behavior
  - To distract from distressing emotions
- And, because it is ineffective
  - Intensity builds
  - Can lead to binge eating and/or purging

1. Stop any behavior that interferes with treatment

2. Stop or decrease any Quality of Life Interfering Behaviors

Path to Mindful Eating

A. Stop Binge Eating and/or Purging
B. Eliminate Mindless Eating
C. Decrease Cravings, Urges, Preoccupation with food
D. Decrease "Capitulating" (i.e., closing off options to not binge and/or purge
E. Decrease "Apparently Irrelevant Behaviors"

Decrease Capitulating

- Acting as if there is no other option or way to cope than with food
- May appear to be passive behavior
- But is an active decision to shut down
  - Give up on goal to stop binge eating and skillfully cope with emotions
- Always have a *choice* to binge or not to

1. Stop any behavior that interferes with treatment

2. Stop or decrease any Quality of Life Interfering Behaviors

<u>Path to Mindful Eating</u>

A. Stop Binge Eating and/or Purging
B. Eliminate Mindless Eating
C. Decrease Cravings, Urges, Preoccupation with food
D. Decrease "Capitulating" (i.e., closing off options to not binge and/or purge
E. Decrease "Apparently Irrelevant Behaviors"

Decrease Apparently Irrelevant Behaviors (AIB)

- Behavior that
  - Initially appears irrelevant to binge eating and/or purging
- Convince oneself behavior "doesn't matter" or "won't really affect" goal to stop binge eating
  - Upon closer examination, it is an important component in the sequence of events
  - Examples of typical AIBs
    - Buying several boxes of "charity biscuits", telling yourself you just want to help raise money for the school
    - Buying food "for company"
    - Buying extra "just in case"
    - Saving leftovers because you don't want to waste ("waist") food

Behavioral Analysis Strategies: Adapted DBT for EDs Treatment Targets

Treatment Goals: Stop Problematic Eating Behaviors

Treatment Targets:

1. **Stop any Life Interfering Behavior**
2. **Stop any behavior that interferes with treatment**
3. **Stop or decrease any Quality of Life Interfering Behavio**

   Path to Mindful Eating

   A. **Stop Binge Eating and/or Purging**
   B. **Eliminate Mindless Eating**
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   D. **Decrease "Capitulating" (i.e., closing off options to not binge eat and/or purge**
   E. **Decrease "Apparently Irrelevant Behaviors"**

4. **Increase Skillful Emotion Regulation Behaviors**

Increase ***Skillful*** Emotion Regulation Behaviors

- MINDFULNESS SKILLS
  - increase awareness and experience of the current moment without self-consciousness or judgment
- EMOTION REGULATION SKILLS
  - help client identify his/her emotions, understand their function, and reduce his/her vulnerability to negative emotions
- DISTRESS TOLERANCE SKILLS
  - help clients more effectively tolerate painful emotional states that cannot, in that moment, be changed through distraction, self-soothing, or acceptance
- REVIEW & RELAPSE STRATEGIES (Sessions 19-20)

Similarities and Differences Between "Standard" DBT and Adapted DBT for EDs: Core DBT Strategies

- **Behavioral Analysis Strategies**
  - ED-Specific Treatment Targets/Therapy-Interfering Behaviors
  - Monitoring and analysis of Problem Behaviors
    - ED-Specific Chain Analysis
    - ED-specific Diary Card
- **Solution Analysis strategies**
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    - Skills acquisition, strengthening, generalization
- **Dialectical Strategies**
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Core DBT Strategies

- ED-Specific Behavioral Analysis Strategies
  - ED-Specific Targets
  - Monitoring and analysis of Problem Behaviors
    - ED-Specific Chain Analysis
    - ED-specific Diary Card

Core DBT Strategies

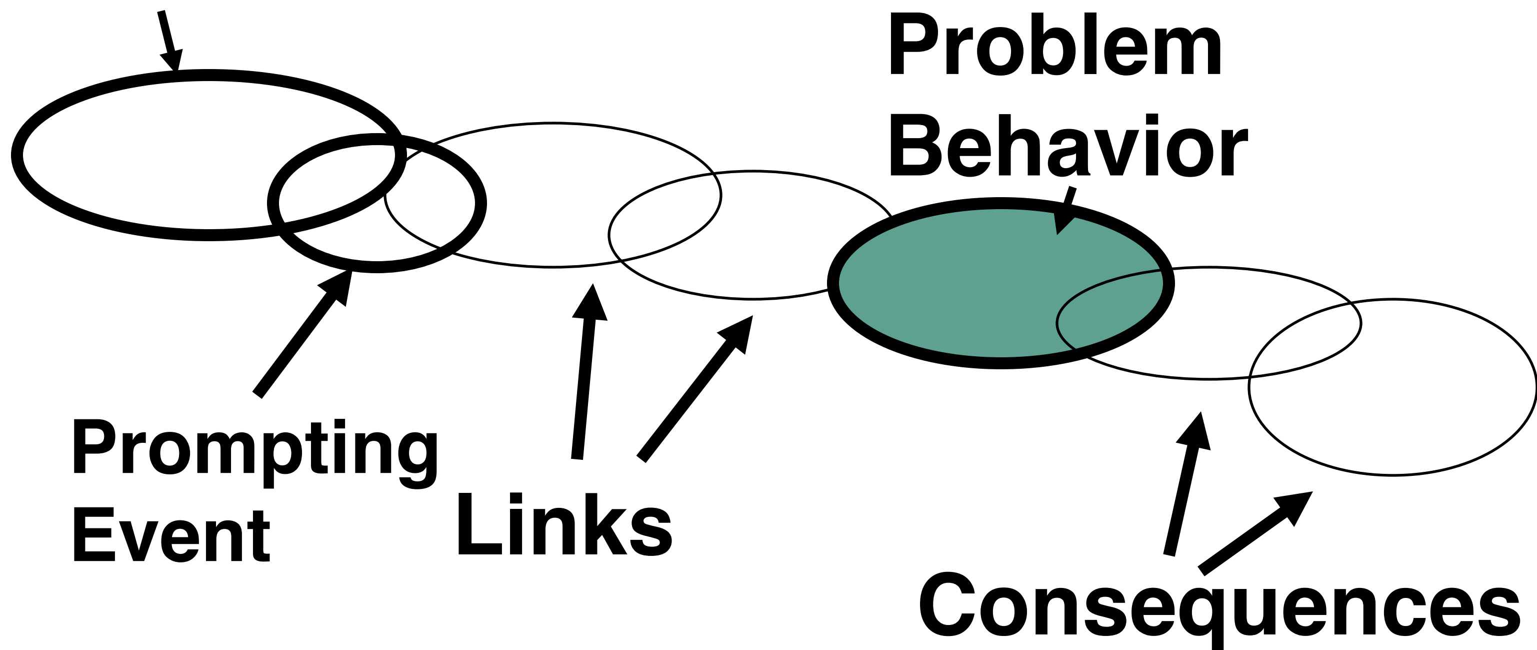
- ED-Specific Behavioral Analysis Strategies
  - ED-Specific Targets
  - Monitoring and analysis of Problem Behaviors
    - ED-Specific Chain Analysis
    - ED-specific Diary Card

ED-Specific Behavioral Chain Analysis

Monitoring and Analysis of Problem Behaviors

- Problem behavior
  - Choose highest on “Path to Mindful Eating” Hierarchy
  - e.g. Binge Eating and/or Purging> Mindless Eating> Food cravings, urges, preoccupations > Capitulating> Apparently Irrelevant Behaviors
- What prompted the behavior?
- What made me vulnerable?
- What were the consequences of the behavior?

Behavioral Chain Analysis



ED-Specific Chain Analysis Work-Sheet

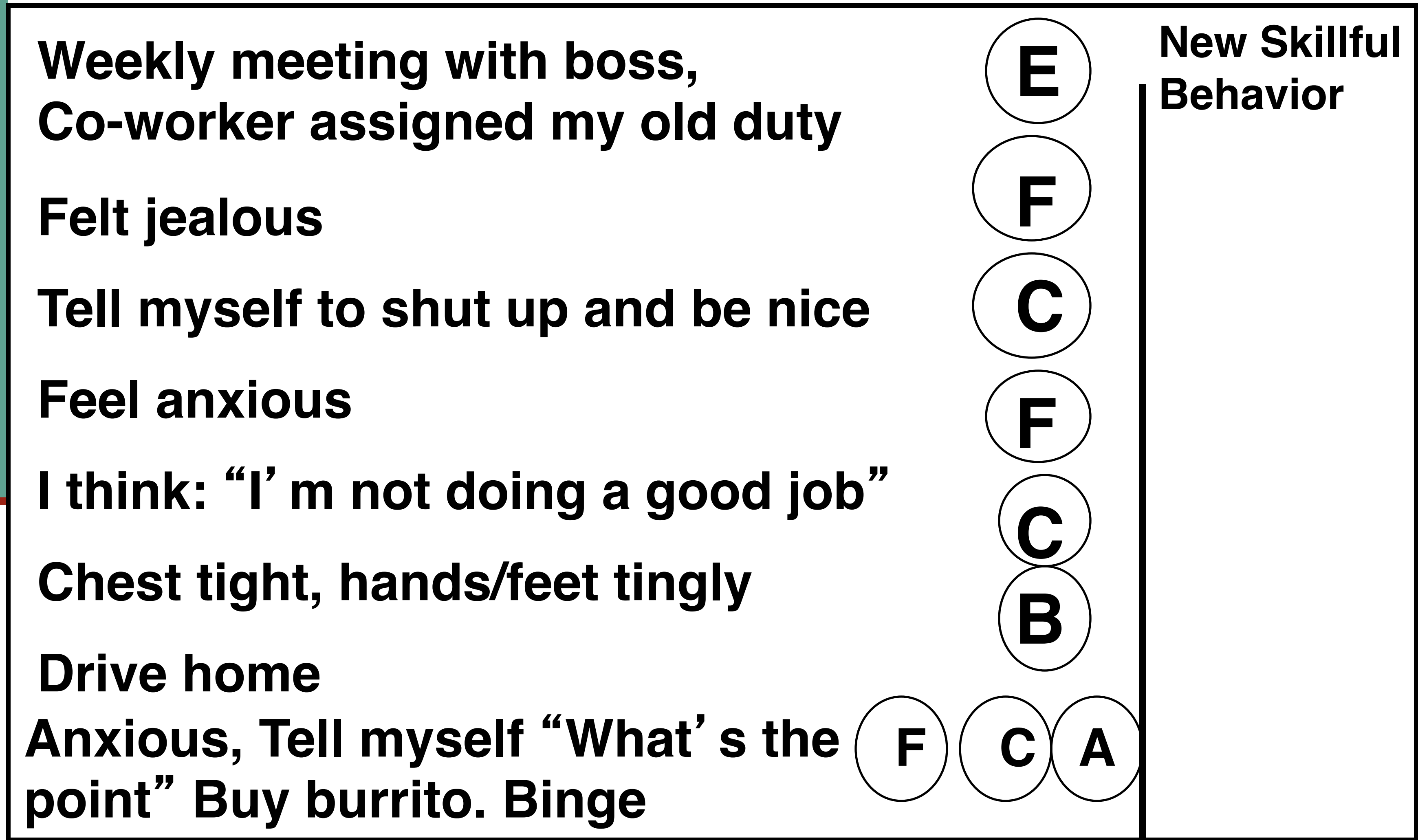
What exactly is the Problem Behavior?
Binged on a very large burrito for dinner

What was the Prompting Event?
Had weekly meeting with boss- co-worker got assigned a duty that used to be mine

What things in my myself and my environment made me vulnerable?
Tired, Stressed; Felt lonely in an empty house
Woke up in morning feeling looked fat

Links of Behavior (p.2 of Chain Analysis)

A-Actions
B-Body Sensation
C-Cognitions
E-Events
F-Feelings



Chain Analysis Work-Sheet (p. 3)

What were the CONSEQUENCES?

Watched movie on Television. Issues at work started to feel unimportant (short term)

Feel depressed and demoralized (longer term)

Ways to reduce my VULNERABILITY in the future? .

Get to bed earlier, do more self-care, add positive events

Plans to REPAIR, CORRECT, and OVER CORRECT

Fill out this chain analysis. Talk to boss about situation .

My deepest thoughts and feelings about this

I need to find a better way to live!

ED-Specific Chain Analysis Work-Sheet

What exactly is the Problem Behavior?
Binged on cheese, sweets, potato chips
at home in the afternoon

What was the Prompting Event?Having to go to a party that evening

What things in my myself and
my environment made me vulnerable?
Ongoing tension and stress with parents, guilt
towards friends, fatigue

Links of Behavior (p.2 of Chain Analysis)

A-Actions
B-Body Sensation
C-Cognitions
E-Events
F-Feelings

1. In home, in bedroom
2. Felt anxious
3. Increased heart beating, breathing
4. Strong urge to eat
5. Anxiety felt impossible to tolerate

E
F
B
B
F

New Skillful Behavior

Breathing
Call friend

Chain Analysis Work-Sheet (p. 3)

What were the CONSEQUENCES?
(Immediate) Felt relief
(Delayed) Felt guilty and ashamed

Ways to reduce my VULNERABILITY in the future?
Go to bed earlier; singing, talk to a girlfriend .

Plans to REPAIR, CORRECT, and OVER CORRECT
Fill out chain, commit to practice skills

My deepest thoughts and feelings about this

Core ED-Specific DBT Strategies

- ED-Specific Behavioral Analysis Strategies
  - ED-Specific Targets
  - Monitoring and analysis of Problem Behaviors
    - ED-Specific Chain Analysis
    - ED-specific Diary Card

ED-Specific DIARY CARD

Day	Urge to Binge (1-6)	# Episodes	Mindless Eating	Anger	Fear	Sad	Pride
Mon							
Tues							
Wed							
Thu							
Fri							
Sat							
Sun							

ED-Specific Diary Card Skills Practice

Circle the days you worked on each Skill					
1. Wise Mind	Mon	Tue	Wed	Thu	Fri
2. Observe	Mon	Tue	Wed	Thu	Fri
3. Describe	Mon	Tue	Wed	Thu	Fri
4. Participate	Mon	Tue	Wed	Thu	Fri
5. Mindful Eating	Mon	Tue	Wed	Thu	Fri
6. Non-judgmentall	Mon	Tue	Wed	Thu	Fri

- Content of ED-Specific DBT
  - Theoretical Foundation: DBT core theories, biosocial model
    - Extending Biological and Invalidating Environment
  - Core ED-Specific DBT Strategies
    - Behavioral Analysis Strategies
      - ED-Specific Treatment Targets
      - Monitoring and analysis of Problem Behaviors
        - ED-Specific Chain Analysis
        - ED-specific Diary Card
    - Solution Analysis Strategies: ED-specific Concepts and Skills
        - *Pre-Commitment: Eliciting Commitment to Stop Binge Eating*
        - *Mindfulness: Mindful Eating, Urge Surfing, Alternate Rebellion*
        - *Emotion Regulation*
        - *Distress Tolerance: Burning Bridges*
        - *Relapse Prevention: Coping Ahead*
    - Dialectical Strategies
      - Dialectical Abstinence

- Content of ED-Specific DBT
  - Theoretical Foundation: DBT core theories, biosocial model
    - Extending Biological and Invalidating Environment
  - Core ED-Specific DBT Strategies
    - Behavioral Analysis Strategies
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        - *Distress Tolerance: Burning Bridges*
        - *Relapse Prevention: Coping Ahead*
    - Dialectical Strategies
      - Dialectical Abstinence

Solution Analysis Strategies

- ED-specific Concepts and Skills
  - Pre-Commitment & Sessions 1 & 2
    - *Eliciting Commitment to Stop Binge Eating*
  - Mindfulness Module
    - *Mindful Eating*
    - *Urge Surfing*
    - *Alternate Rebellion*
  - Emotion Regulation Module
  - Distress Tolerance
    - *Burning Bridges*
  - Relapse Prevention
    - *Coping Ahead*

Case Example

- 46 y. o. married woman, full-time mother of two.
- Twenty-five lbs overweight.
- Began binge eating in adolescence
- Binge eating worsened over past year when elderly mother had a stroke and moved in to live with patient's family.

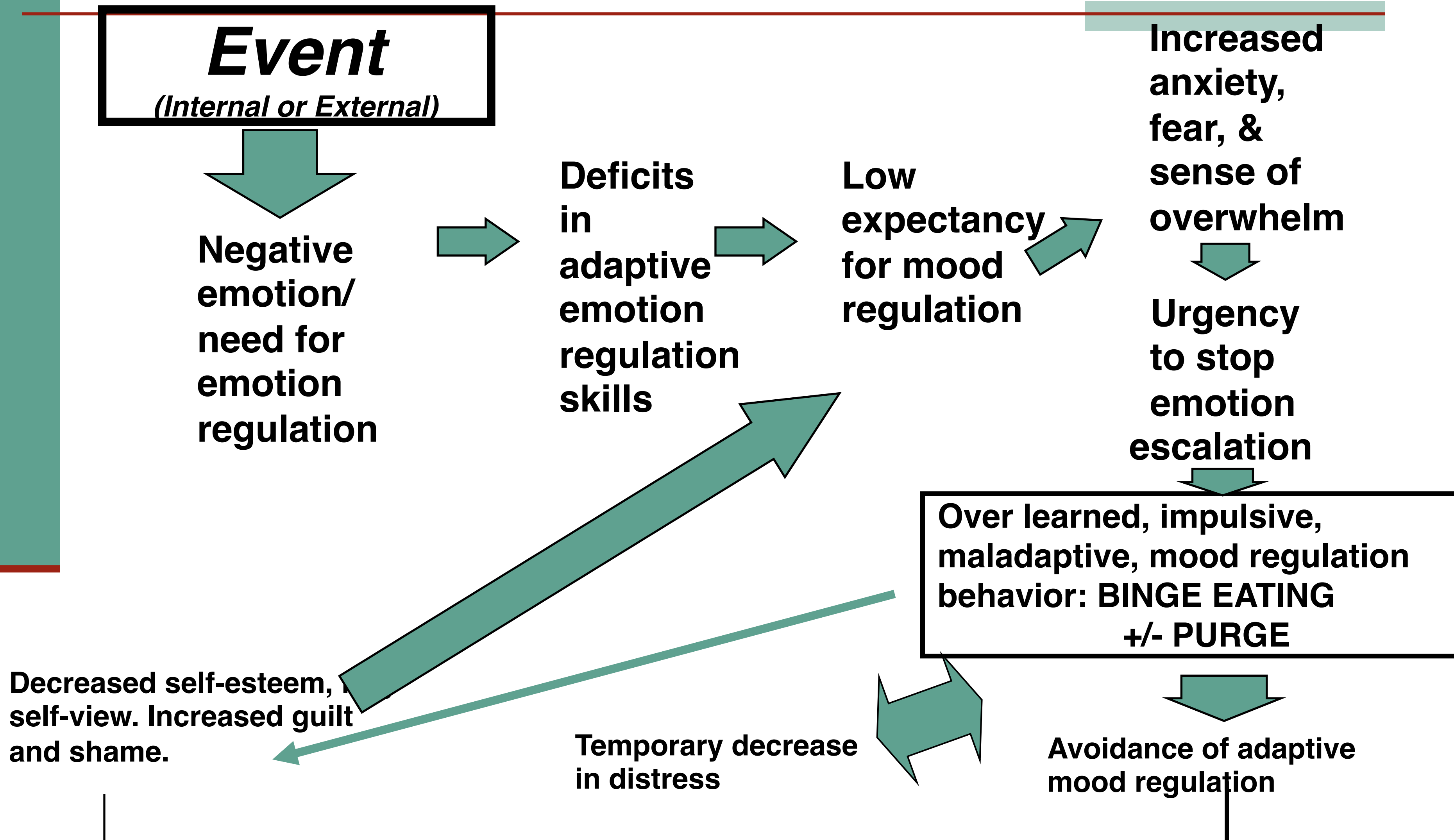
Goals of Pre-Treatment Interview

- Develop a therapeutic alliance
- Gain an understanding of the patient's overall eating difficulties
- Provide clients with a rationale for DBT treatment
- Orient client to treatment and obtain commitment
- Review treatment expectations for the client and the therapist
- Provide logistical information and opportunity for questions
- Convey enthusiasm

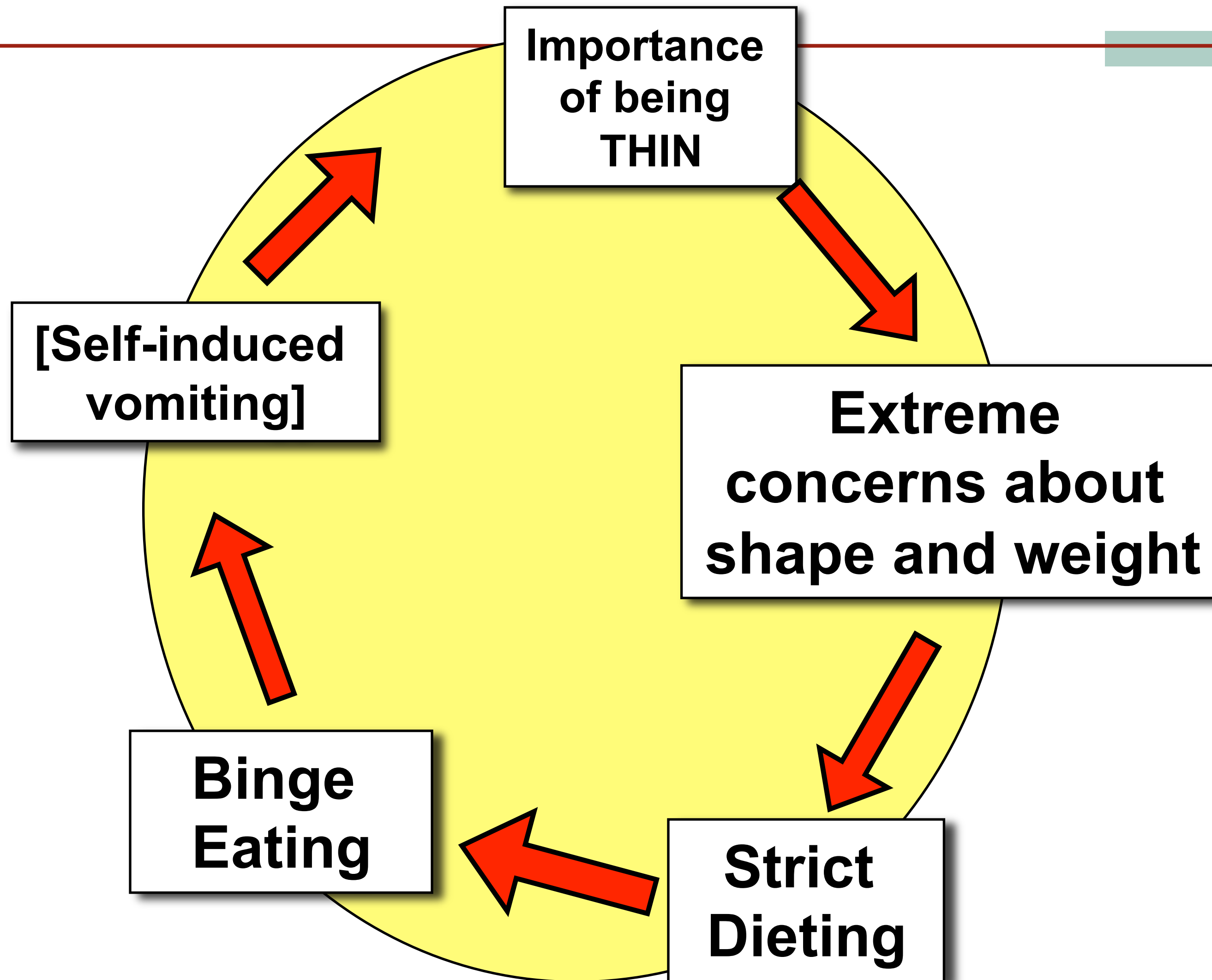
Pre-Treatment Interview

- Individual meeting with therapist
- 20-30 minutes
- Introduce Emotion Regulation Model
  - Review recent binge, does model apply?
- Review Treatment Targets
- Review Client and Therapist Agreements

Pre-Treatment Orientation to DBT Model for Maladaptive Emotion Regulation



What would be the CBT Formulation?



From Wisniewksi L., citing Fairburn, Marcus, & Wilson (1993, p.369)

ROLE PLAY

Pre-Commitment

Client's Treatment Agreements

1. I agree to arrive at sessions on time.
2. I agree to attend sessions each week and to stay for the entire (2 hour) (50 minute) session.
3. I agree to call ahead of time if I will miss or be late for a session.
4. I agree to practice the skills taught.
5. I agree to do my absolute best to stop binge eating (and purging_.
6. I agree to complete the homework assignments and bring them with me to each session.
7. [Note: If applicable] I agree to complete the research questionnaires and interviews that are part of this treatment program.

Client's signature____________________Date_____

Pre-Commitment

Therapist's Treatment Agreements

1. I agree that I will keep confidential the information discussed, including the [names of group members]
2. [Note: If applicable] I agree not to form private relationships with other group members outside of group sessions.
3. I agree to arrive at sessions on time.
4. I agree to attend sessions each week and to stay for the entire [2 hour] or [50 minute] session.
5. I agree to inform the group if I will miss or be late for a session. [If applicable] If I miss a session I agree to listen to the recorded (e.g. audiotaped/videotaped) session.
6. I agree to practice the skills taught.
7. I agree to do my absolute best to deliver the best treatment that I can to help [group members] stop binge eating [and purging].

__________ _________

Therapist's Signature Date

Sessions 1 & 2

- **Session 1**
  - Introductions
  - Commitment to Abstinence from Binge Eating/ Pros & Cons of Binge Eating
  - Orientation to Treatment
    - Emotion Regulation Model/Biosocial Model
    - Review of targets
      - Treatment interfering behavior/Path to Mindful Eating/ Treatment agreements.
    - ED-diary card, ED targeted chain analysis
    - 3x5 card
      - Side 1= Top 5 negative consequences of binge eating
      - Side 2= Top 5 positive consequences of stopping binge eating
- **Session 2**
  - Dialectical Abstinence concept
  - Diaphragmatic breathing
  - Review chain analysis

Session 1

- Introductions
- Commitment to Abstinence from Binge Eating/ Pros & Cons of Binge Eating
- Orientation to Treatment
  - Emotion Regulation Model/Biosocial Model
  - Review of targets
    - Treatment interfering behavior/Path to Mindful Eating/ Treatment agreements.
  - ED-specific diary card, ED-specific chain analysis
  - 3x5 card
    - Side 1= Top 5 negative consequences of binge eating
    - Side 2= Top 5 positive consequences of stopping binge eating

Commitment to Binge Abstinence

- Elicit pros/cons of Binge Eating

- Devil's Advocate Strategy:
  - **"Therapist: "I don't understand. Why can't you have a high quality of life and stay a binge eater?"**
    - Members state "cons" of binge eating
    - Therapist presses for "pros"
      - "There must be some benefits . . ."
  - **Therapist: "You haven't convinced me. Why can't you continue to binge and still have a high quality life?"**
  - **[Polarize argument]**
    - "By having a high quality of life we don't mean one in which you simply get by or minimize pain. It's one that's deeply rewarding, where you feel fully alive and *very very* good about yourself"
- Group members make verbal commitment to abstinence from binge eating

ROLE PLAY OF PROS/CONS
OF BINGE EATING AND
OBTAINING COMMITMENT

Session 1

Introductions

- Commitment to Abstinence from Binge Eating/ Pros & Cons of Binge Eating
- Orientation to Treatment
  - Emotion Regulation Model/Biosocial Model
  - Review of targets
    - Treatment interfering behavior/Path to Mindful Eating/ Treatment agreements.
  - Introduce ED-Specific Diary Card, ED-Specific Chain Analysis
  - 3x5 card skill
    - Side 1= Top 5 negative consequences of binge eating
    - Side 2= Top 5 positive consequences of stopping binge eating

ED-Specific DIARY CARD

Day	Urge to Binge (1-6)	# of Episodes	Mindless Eating	Anger	Fear	Sad	Pride
Mon							
Tues							
Wed							
Thu							
Fri							
Sat							
Sun							

Diary Card Skills Practice

Circle the days you worked on each Skill					
Wise Mind	Mon	Tue	Wed	Thu	Fri
Observe	Mon	Tue	Wed	Thu	Fri
Describe	Mon	Tue	Wed	Thu	Fri
Participate	Mon	Tue	Wed	Thu	Fri
Non-judgmental	Mon	Tue	Wed	Thu	Fri
One-mindful	Mon	Tue	Wed	Thu	Fri

Chain Analysis Work-Sheet

What exactly is the Problem Behavior?

Binged on dessert foods bought at grocery store on Friday

What was the Prompting Event?

Sister called requesting I drive mother to a doctor' s appointment at the last minute

What things in my myself and my environment made me vulnerable?

Tired, anxious about an upcoming social event, not feeling close to husband

Links of Behavior

(p.2 of Chain Analysis)

A-Actions
B-Body Sensatio
C-Cognitions
E-Events
F-Feelings

Links		New Skillful Behavior
Sister calls	E	
Felt angry	F	
Tell myself I should be nice	C	
Feel anxious	F	
I think: “It’ s not fair. I do everything.”	C	
Chest tight, hands/feet tingly	B	
Drive to store	A	
Anxious, Tell myself “Who cares?”	F C	
Buy dessert items. Binge	A	

Links of Behavior

(p.2 of Chain Analysis)

A-Actions
B-Body Sensatio
C-Cognitions
E-Events
F-Feelings

Links		New Skillful Behavior
Sister calls	E	Observe
Felt angry	F	Non-judgmental
Tell myself I should be nice	C	
Feel anxious	F	
I think: "It' s not fair. I do everything."	C	
Chest tight, hands/feet tingly	B	
Drive to store	A	
Anxious, Tell myself "Who cares?"	F C	
Buy dessert items. Binge	A	

Chain Analysis Work-Sheet (p. 3)

What were the CONSEQUENCES?

Isolated and watched TV, didn' t interact with children or husband (immediate). Felt full, fat; Doctor's appointment felt unimportant

Ways to reduce my VULNERABILITY in the future?

Speak up to sister. Do more self-care activities

Plans to REPAIR, CORRECT, and OVER CORRECT

Fill out this chain analysis. Promise try 3 skills next time .

My deepest thoughts and feelings about this

I'm sick of doing this. I'm sick of myself

Session 1

Introductions

- Commitment to Abstinence from Binge Eating/ Pros & Cons of Binge Eating
- Orientation to Treatment
  - Emotion Regulation Model/Biosocial Model
  - Review of targets
    - Treatment interfering behavior/Path to Mindful Eating/ Treatment agreements.
  - Introduce ED-Specific Diary Card, ED-Specific Chain Analysis
  - 3x5 card skill
    - Side 1= Top 5 negative consequences of binge eating
    - Side 2= Top 5 positive consequences of stopping binge eating

Session 1: 3 X 5 Card

Side 1= Top 3 positive consequences of stopping binge eating

1.
2.
3.
4.
5.

Side 2= Top 3 negative consequences of continuing to binge eat

1.
2.
3.
4.
5

"Nuts and Bolts": Pre-Commitment ED-Specific Concepts and Skills

Sessions 1 & 2

- **Session 1**
  - Introductions
  - Commitment to Abstinence from Binge Eating/ Pros & Cons of Binge Eating
  - Orientation to Treatment
    - Emotion Regulation Model/Biosocial Model
    - Review of targets
      - Treatment interfering behavior/Path to Mindful Eating/ Treatment agreements.
    - ED-diary card, ED targeted chain analysis
    - 3x5 card
      - Side 1= Top 5 negative consequences of binge eating
      - Side 2= Top 5 positive consequences of stopping binge eating
- **Session 2**
  - ED-Specific Dialectical Abstinence concept
  - ED-Specific Diaphragmatic breathing
  - Review chain analysis

Session 2

- ED-Specific Dialectical Abstinence concept
- ED-Specific Diaphragmatic breathing
- Review chain analysis

ED- Specific Concept: Dialectical Abstinence

- Taken from DBT for substance abuse (Linehan & Dimeff, 1999)
- Synthesis of a 100% commitment to abstinence and a 100% commitment to relapse management strategies
- BEFORE a patient engages in binge eating, there is an unrelenting insistence on total abstinence.
- AFTER a client has binged, the emphasis is on radical acceptance, nonjudgmental problem solving and effective relapse prevention, followed by a quick return to the unrelenting insistence on abstinence.
- Metaphor of Olympic Athlete (Telch, 1997)

Olympic Athlete Metaphor

- "A good mental picture is an Olympic athlete"
- When the athlete is training, nothing is discussed except winning and going for the gold.
- If the Olympian athlete thought or said that winning a bronze medal would be "fine", then their training mentality and performance would be affected.

Olympic Athlete Metaphor (cont.)

- The athlete is similar to the client
  - The client can only Focus on absolute and total binge abstinence
  - Yet of course client must also be prepared for the possibility of failure
- The key is to be prepared to **fail well**

Session 2

- ED-Specific Dialectical Abstinence concept
- ED-Specific Diaphragmatic breathing
- Review chain analysis

ED- Specific Skill: Diaphragmatic Breathing

- Deceptively simple
- Rated by many clients as their #1 skill
- Always "right under your nose"
- Learning and practicing deep breathing and focusing on the breath helps relieve emotional distress and physical tensions that have built up and may trigger urges to binge (and purge).
- Experiential Exercise

Mindfulness Module:(Sessions 3-5)

Session 3: Three States of Mind (Mindfulness Handout 1)

- Reasonable Mind, Emotion Mind, Wise Mind

Session 4: "What" Skills (Mindfulness Handout 2)

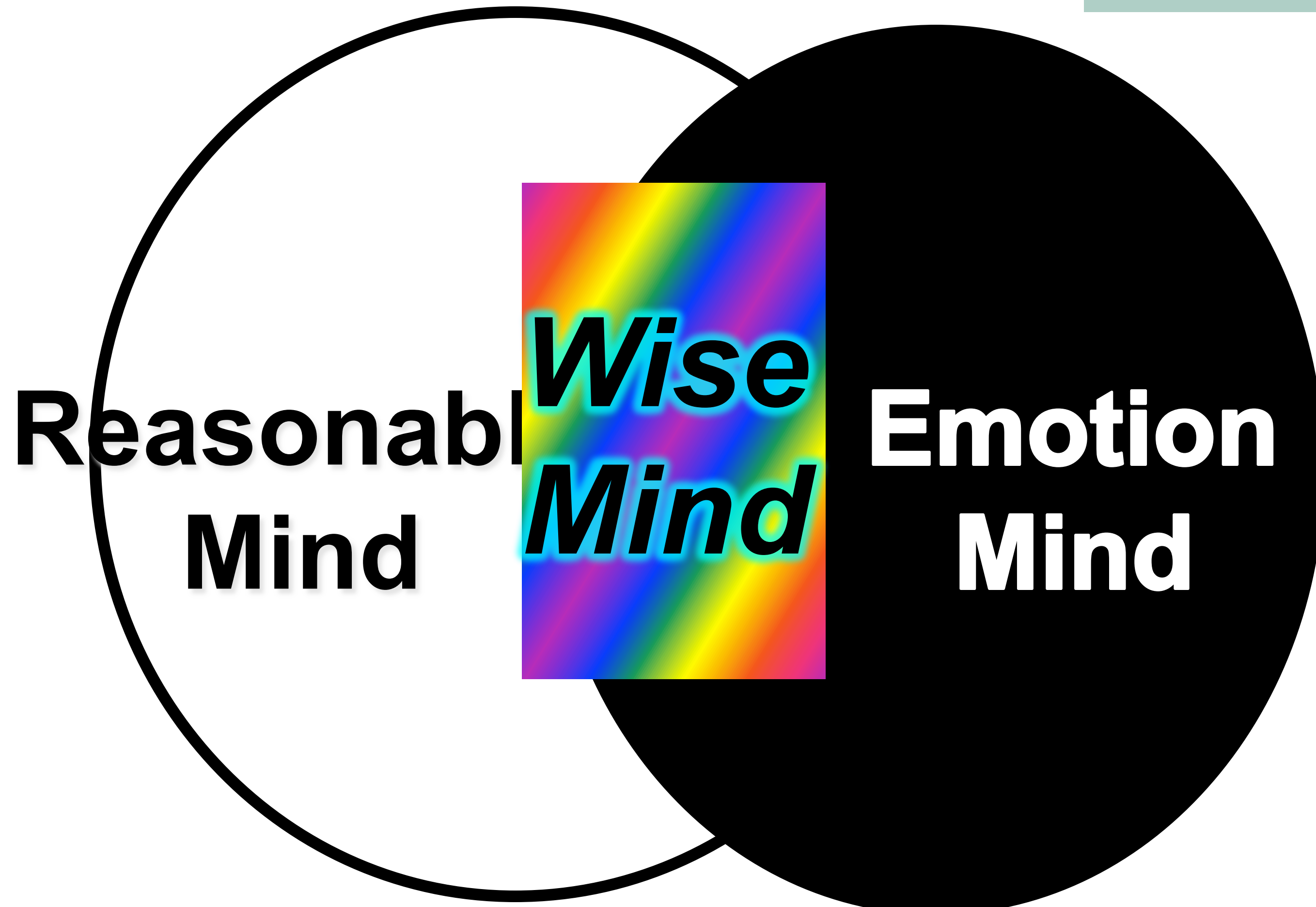
- Observe, Describe, Participate
- Mindful eating exercise with raisins

Session 5: "How" Skills (Mindfulness Handout 3)

- Non-judgmentally, One-mindfully, Effectively
- Urge Surfing & Alternate Rebellion

From Skills Training Manual for Treating Borderline Personality by Marsha Linehan. 1993. The Guilford Press.

ED-Specific DBT Applications: Wise Mind



Wise Mind is **INCOMPATIBLE** With Binge Eating

(Linehan 1993)

ED-Specific Mindfulness Skills: Session 4

- "What" Skills

(Mindfulness Handout 2)

  - Observe
  - Describe
  - Participate
  - Mindful Eating exercise (with raisins)

From Skills Training Manual for Treating Borderline Personality by Marsha Linehan. 1993. The Guilford Press.

ED-Specific DBT Skills: Mindful Eating

Mindful Eating (e.g. a raisin, chocolate kiss)

"What" Skills

- Observe and describe the experience
- Notice what comes through your senses -eyes, nose, ears, tongue, body
- Describe the experience in words
- Watch thoughts and feelings, letting them come into mind and slip right out ("Teflon Mind")

"How" Skills

- Eat non-judgmentally
- One-mindfully
- Effectively

(Kabat-Zinn, 1990; Linehan 1993)

ED-Specific Mindfulness Skills: Session 5

"How" Skills

(Mindfulness Handout 3)

- Non-judgmentally
- One-mindfully
- Effectively

- Urge Surfing (with chocolate chip, malt ball, etc.)

- Alternate Rebellion

From Skills Training Manual for Treating Borderline Personality by Marsha Linehan. 1993. The Guilford Press.

ED Specific DBT Skills: Urge Surfing & Alternate Rebellion

Urge Surfing

- Nonjudgmental observing and describing of urges to binge
- Detach from urge, staying fully in the moment "riding the wave" of the urge
- In-session practice with malt-ball, chocolate, etc.
- Borrowed from DBT for Substance Abuse

(Linehan & Dimeff, 1999;Telch, 1997)

ED Specific DBT Skills: Urge Surfing & Alternate Rebellion

Alternate Rebellion

- Nonjudgmental observation of the desire to rebel or retaliate
- Uses Wise Mind to rebel effectively, without destroying the commitment to stop binge eating or purging
- Also borrowed from DBT for Substance Abuse

(Linehan & Dimeff, 1999;Telch, 1997)

Emotion Regulation (Sessions 6-8)

Session 6

- Goals of Emotion Regulation Training (E.R. Handout 1)
- Letting go of Emotional Suffering (E.R. Handout 9)

Session 7

- Parts of Emotions (E.R. Handout 3); Ways to Describe Emotions (E.R. Handout 4); Homework observe and describe emotions (E.R. Homework 1)

Session 8

- Function of Emotions (E.R. Handout 5)
- E.R. Homework 1 (Observe/Describe) and E. R. Homework 2 (Emotion Diary) *From* Skills Training Manual for Treating Borderline Personality by Marsha Linehan. 1993. The Guilford Press.

Goals of Emotion Regulation Module

- Identify and label emotions
- Increase the number of positive experiences
- Increase mindfulness to emotions
- Understand the function of emotions
- Learn to change emotions when doing so would be effective

Model of Emotions

Interpretation of Event

rompting
vent 1

Prompting

After effects

Brain Change

(neuro-chemical)

Face and Body Change

(e.g. muscles, nerve signals, blood vessels, heart rate, temperature)

Face and Body Language

(e.g facial expression, posture, skin colour)

Expression with words

Emotion

Name

Function of Emotions

1. Emotions Communicate to and Influence Others.
2. Emotions Organize and Motivate Action
3. Emotions Can be Self-Validating

Emotion Regulation (Sessions 9-11)

Session 9

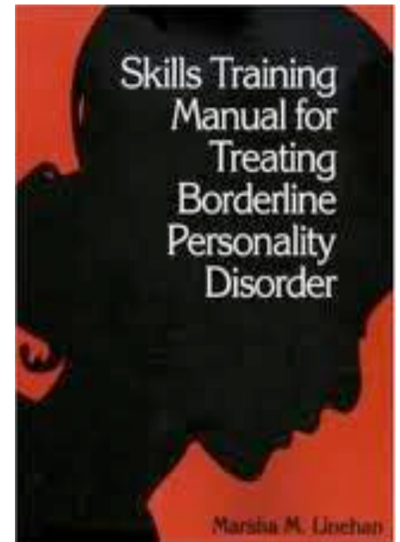
- Reducing Vulnerability to Negative Emotions (E.R. Handout 6);
- Increasing Positive Emotions (E.R. Handouts 7, 8); E.R.Homework Sheet 3

Session 10

- Acting Opposite (E.R.Handout 10)
- E.R. Homework sheets 1 and 3

Session 11

- Myths about Emotions (E.R.Handout 2)

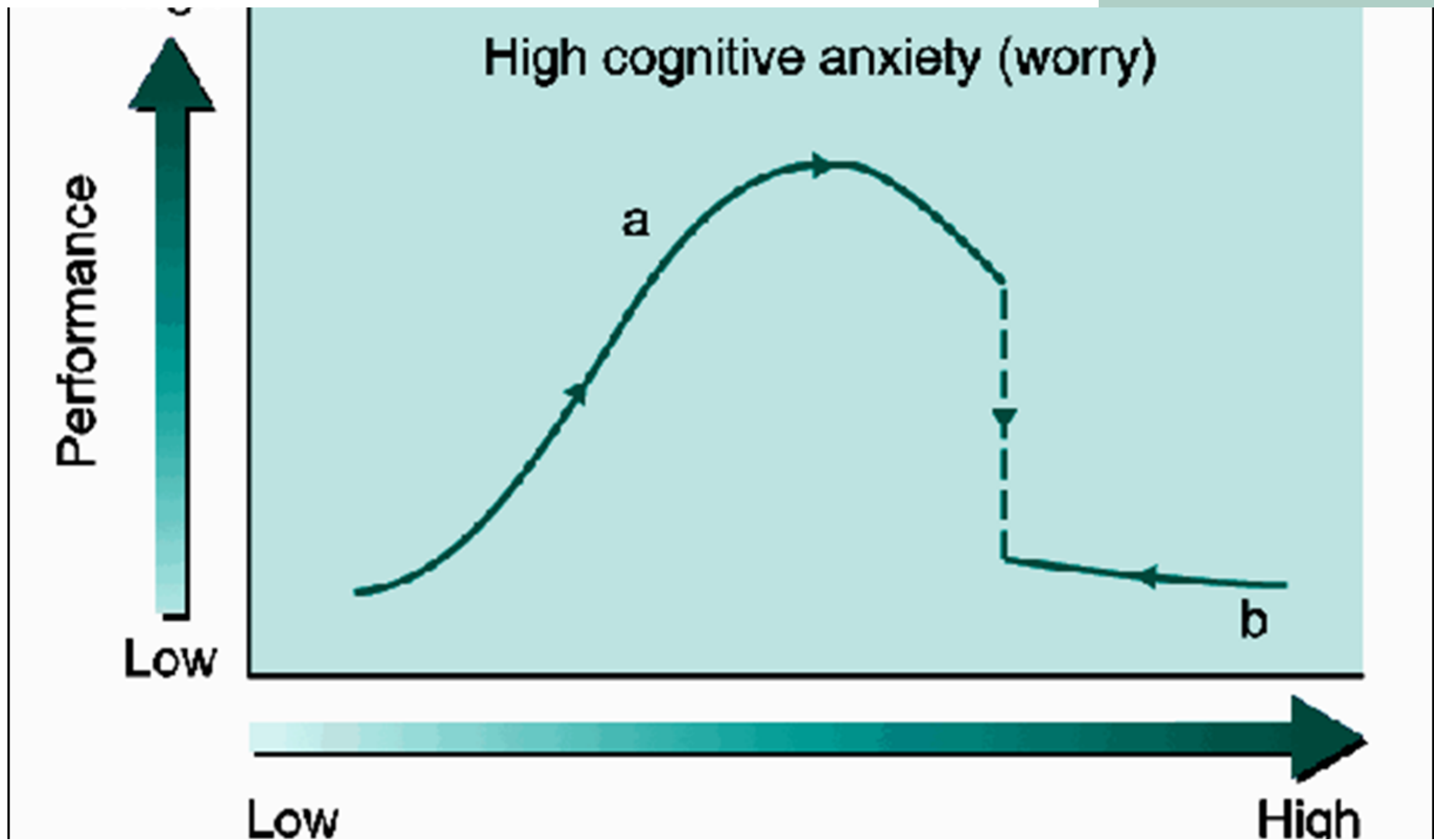


From Skills Training Manual for Treating Borderline Personality by Marsha Linehan. 1993. The Guilford Press.

Reducing Vulnerability to Emotions

- treat Physical illness
- balance Eating
- avoid mood-Altering drugs
- balance Sleep
- get Exercise
- build M A S T E R y

Emotional Exposure Theory



Acting Opposite Emotions

FEAR

- Do what you are afraid of doing....OVER AND OVER AND OVER.
- Approach events, places, tasks, activities, people you are afraid of.
- Do things to give yourself a sense of CONTROL and MASTERY.
- When overwhelmed, make a list of small steps or tasks you can do.
- DO the first thing on the list.

Acting Opposite Emotions

GUILT OR SHAME

- When guilt or shame is JUSTIFIED (emotion FITS your wise mind values)
- Repair the transgression.
- Say your sorry, apologize.
- Make things better, do something nice for person you offended (or someone else if that is not possible).
- Commit to avoiding that mistake in the future.
- Accept the consciences gracefully.
- Then let it go.

Acting Opposite Emotions

GUILT OR SHAME

- When guilt or shame is UNJUSTIFIED (emotion DOES NOT fit your wise mind values)
- Do what makes you feel guilty or ashamed....OVER AND OVER AND OVER.
- Approach, don't avoid

SADNESS OR DEPRESSION

- Get active, approach, don't avoid.
- Do things that make you feel competent and self-confident.

Reduced Vulnerability To Emotion Mind

- Treat physical illness
- Balance eating
- Off Mood-altering drugs
- Balance sleep
- Exercise
- Practice mastery

Emotion Regulation Module (con't)

- Binge eating (and Purging) as an emotional expression of behavior
  - Part of the "action" component of an emotional response
  - Functions (whether intentional or not)
    - Communicating to others
    - Influencing others
    - Communicating to oneself
  - Very difficult to change this response, despite client's strong desire to do so

Emotion Regulation Module (con' t)

- Binge eating and/or purging is NOT acting opposite
  - Part of an attempt, albeit maladaptive, to use behavior to change the experience of distressing emotions
- Binge eating is acting consistently with the emotion
    - When angry
      - Binge eating (and purging) may be an expression of aggression even without an outward attack
    - When feeling guilt or shame
      - Binge eating (and purging) may express the urge to self-attack and punish

  - Because binge eating (and purging) is more or less consistent with the current emotion, these numbing or escaping behaviors serve to **prolong** the emotion rather than change it

Review: (Sessions 12- 13)

- **Session 12:**
  - Review of Emotion Regulation
  - Skill Strengthening
    - Review all handouts

- **Session 13:**
  - Review of Core Mindfulness Skills
  - Skill Strengthening
    - Observe (e.g. Find your lemon on the table)
    - Review all handouts

Distress Tolerance: (Session 14-16)

- **Session 14**
  - Orientation to Distress Tolerance
  - Guidelines for Accepting Reality (D. T. Handout 2 Observing Your Breath)
- **Session 15**
  - Half-smiling (Distress Tolerance Handout 3)
  - Awareness Exercises (D.T. Handout 4)
- **Session 16**
  - Orientation to Acceptance Skills--Radical Acceptance (D.T.Handout 5); Burning Bridges; (D.T. Homework sheet)

From Skills Training Manual for Treating Borderline Personality by Marsha Linehan. 1993. The Guilford Press.

ED-Specific Distress Tolerance Skills
Burning Bridges

- Radically accepting from deep within that one is not going to binge eat, mindlessly eat, or ever again engage in problematic eating behaviors.
- One is "burning the bridges" to those behaviors.
  - Visualization Exercise

ED-Specific Distress Tolerance Skills

Burning Bridges

Practice-Exercise

Distress Tolerance: (Sessions 17-18)

Session 17

- Crisis Survival Skills- Distracting, Self-Soothing; Improve the Moment; Pros and Cons; (D.R. Handout 1); D.R. Homework sheet 1

Session 18

- Review of Distress Tolerance and Skill Strengthening (Review all handouts)

From Skills Training Manual for Treating Borderline Personality by Marsha Linehan. 1993. The Guilford Press.

Relapse Prevention (Sessions 19-20)

- **Session 19**
  - Review of Mindfulness, Emotion Regulation, Distress Tolerance
  - Coping Ahead (Mental Simulation)
  - Planning for the Future
    - Detail specific plans for continuing to practice skills taught
    - Identify 3 emotions that, in your experience, have commonly been difficult to cope with and which often have led you to binge eat. Outline plans for dealing with each of these emotions in the future. Make specific plan for what skills you will use to help you avoid any problem eating behaviors.
    - Write about what you need to do next in your life to continue to building a satisfying and rewarding quality of life for yourself
- **Session 20**
  - Discuss plan; Goodbyes

Mental Simulation/Coping Ahead

- Particularly useful with treatment ending
- Turn to this skill when anxious about an upcoming situation and how one may respond
  - As opposed to Chain Analysis, where goal is to examine past to better understand what could have been done differently
  - Goal of Coping Ahead is to move that analysis into the future
- Key with Coping Ahead is to be very specific
- The client rehearses in detail what he/she would actually say to themselves and what they would actually do

Mental Simulation/Planning Ahead

- Example of Coping Ahead for Specific Emotions
  - Anger
    - Turn to Wise Mind
    - Alternate Rebellion
  - Hopelessness
    - Turn the mind, remind don't have to capitulate
    - Look at diary card, remind me of all the skills I know
  - Ashamed/Self-critical
    - Radical Acceptance
    - Nonjudgmental Stance

After 20 sessions . . .

- Patient had stopped binge eating and all other problem eating behaviors
- Mood much improved, greater confidence
- Relationships with husband, children, other family members, and friends much more satisfying.
- Lost 10 pounds
- Plans in place to prevent relapse
  - Keep therapeutic relationship in mind for difficult times
  - Growth is ongoing process (skills now are "Life Skills")

Rapid Response to Treatment: A Robust Construct

- Rapid response (RR) is a significant early decline (e.g., within 2-4 weeks) in symptomatology during treatment
  - RR predicts successful outcome in depression, bulimia, more recently- BED
    - Participants with ≥ 65% reduction in binge frequency between sessions 1-4 showed predicted improved outcome

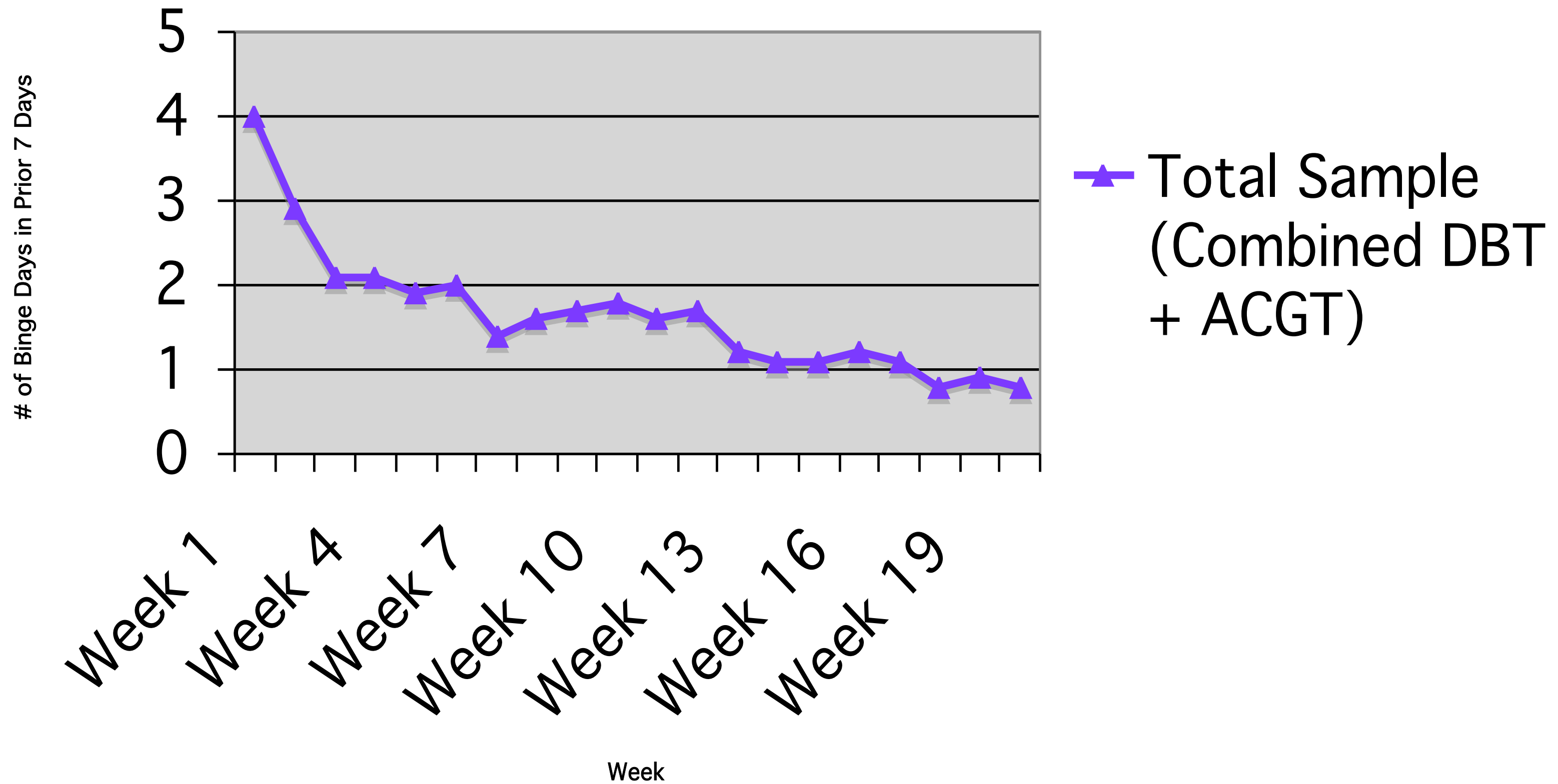
- Mechanism of RR unclear
  - Most studies of RR in BED unable to identify baseline differences between RRs and non-RRs

- To date, RR in BED investigated in individual format treatments
  - e.g., CBT, CBT-guided self-help, behavioral weight loss- guided self help +/- pharmacotherapy (fluoxetine, placebo control, orlistat)

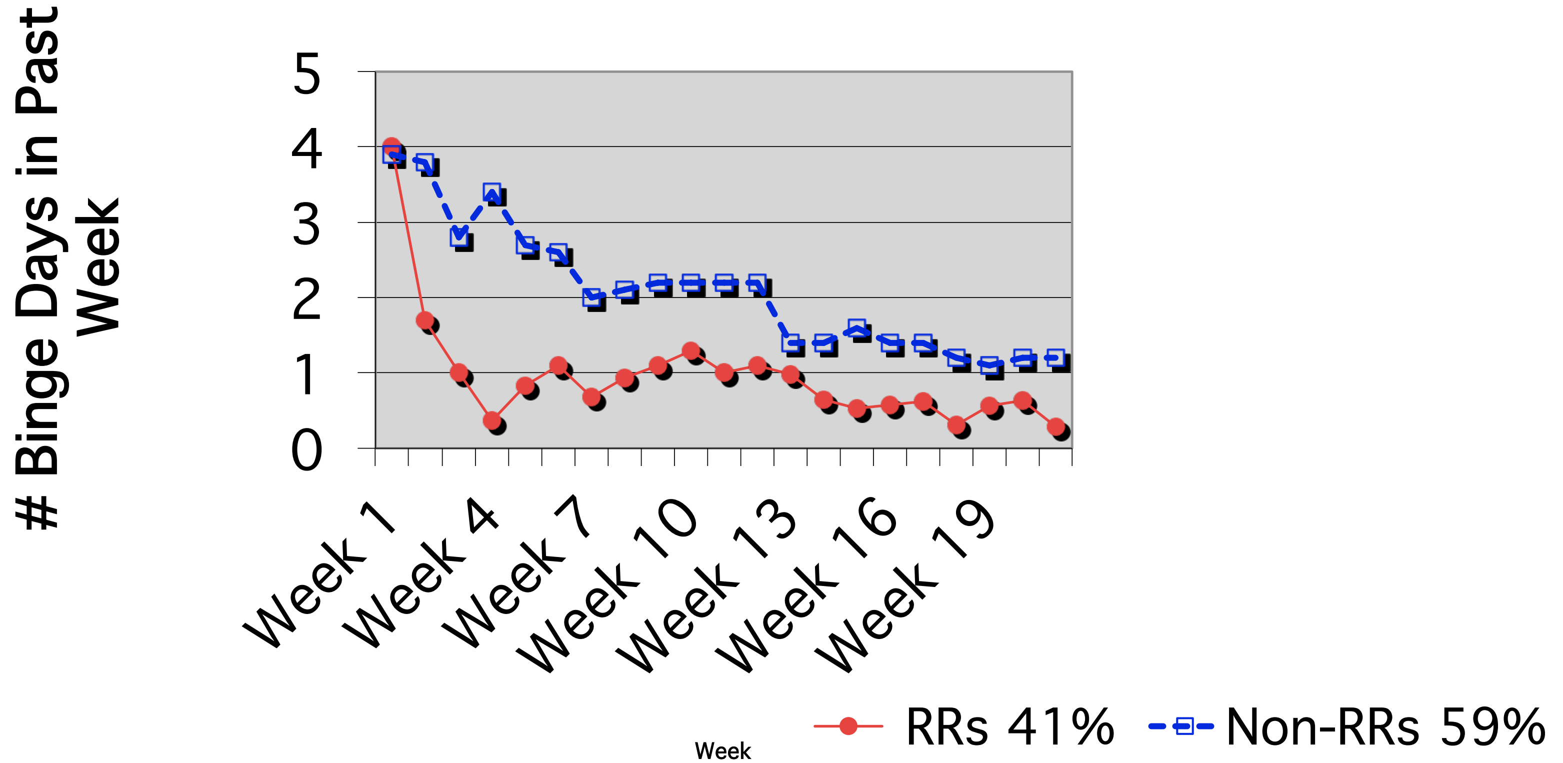
- RR had not yet been examined in a group therapy format or with DBT or an active comparison control group therapy as treatment conditions

Ilardi & Craighead, 1994; Fairburn, Agras, Walsh, Wilson, & Stice, 2004; Grilo, Masheb, & Wilson, 2006

Binge Eating Frequency for Prior Week During Course of Therapy: DBT + ACGT (Active Comparison Group Therapy)



Binge Eating Frequency Over Course of Treatment: Rapid Responders versus Non-Rapid Responders

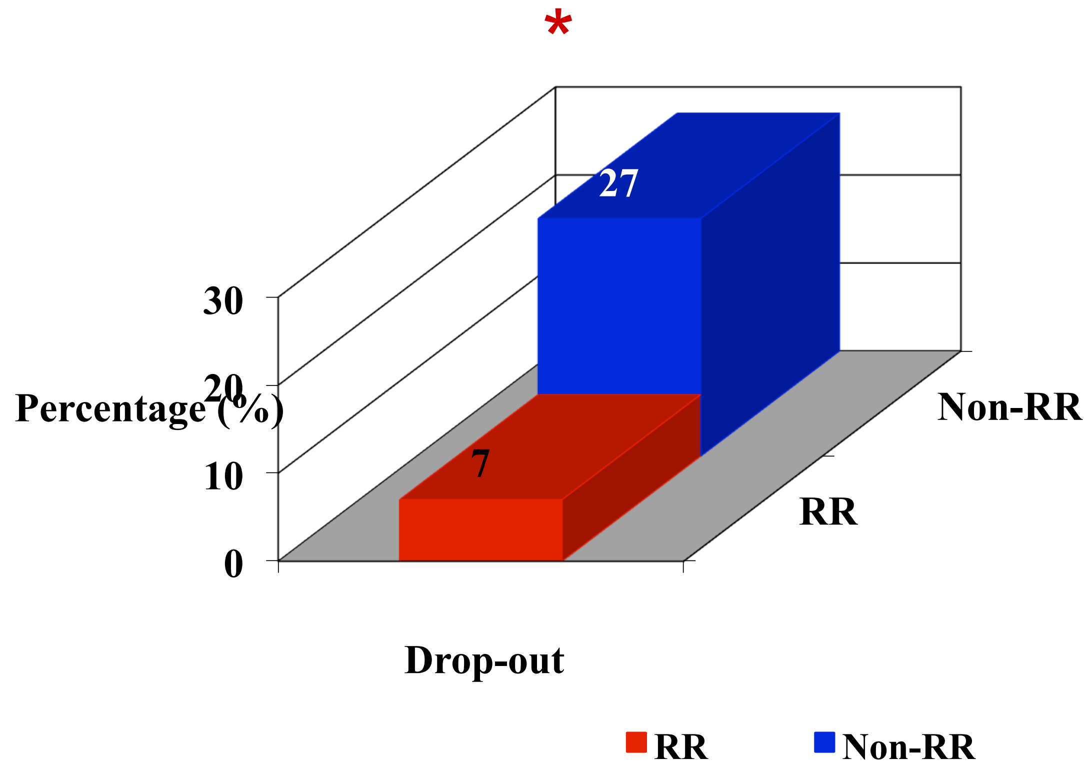


RR = $\geq$ 65% reduction in 4 weeks
Non-RR = < 65% reduction in 4 weeks (as per Grilo, Masheb, & Wilson, 2006)

Safer & Joyce, 2011

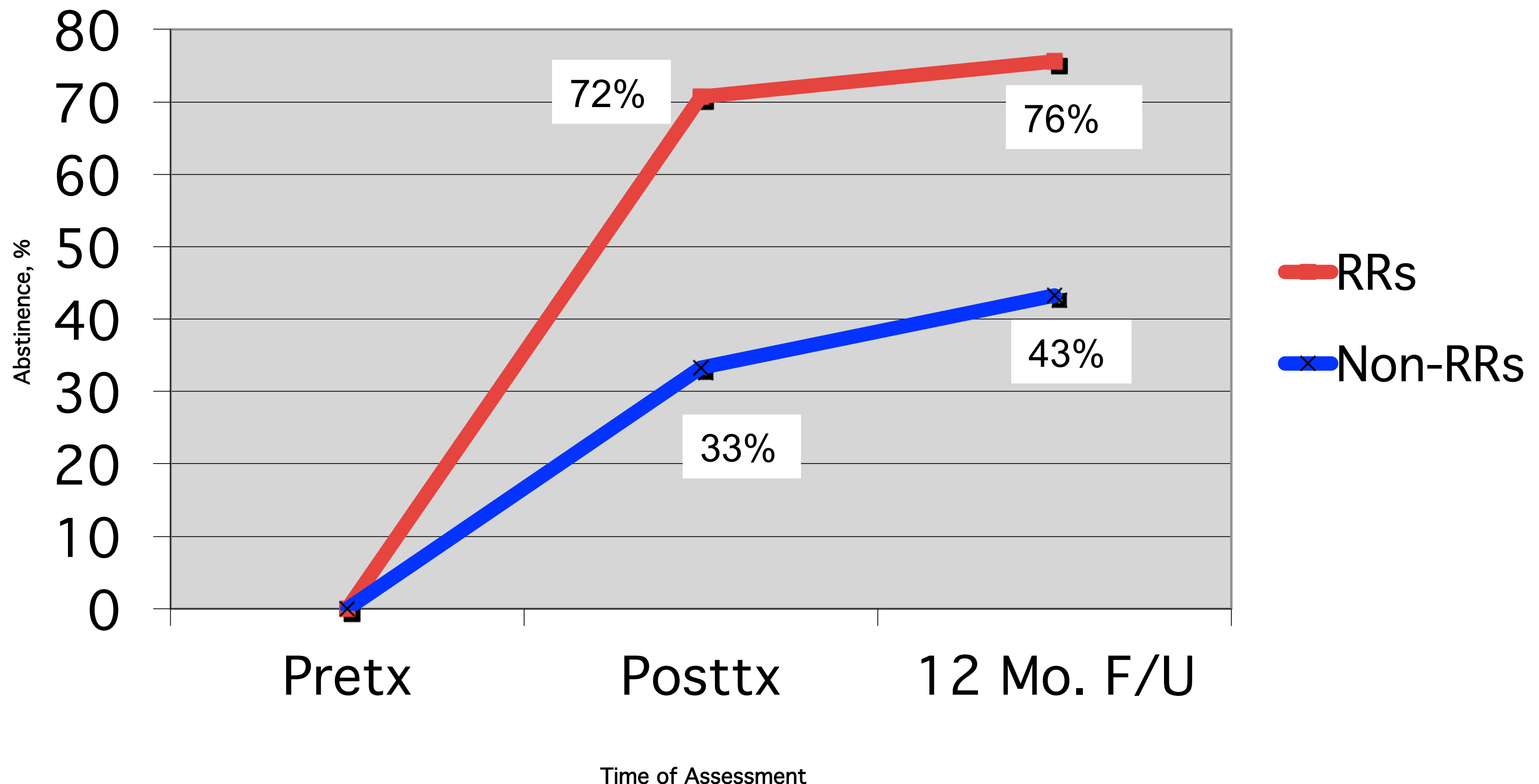
Treatment Drop-out Rates: Rapid Responders versus Non-Rapid Responders

*

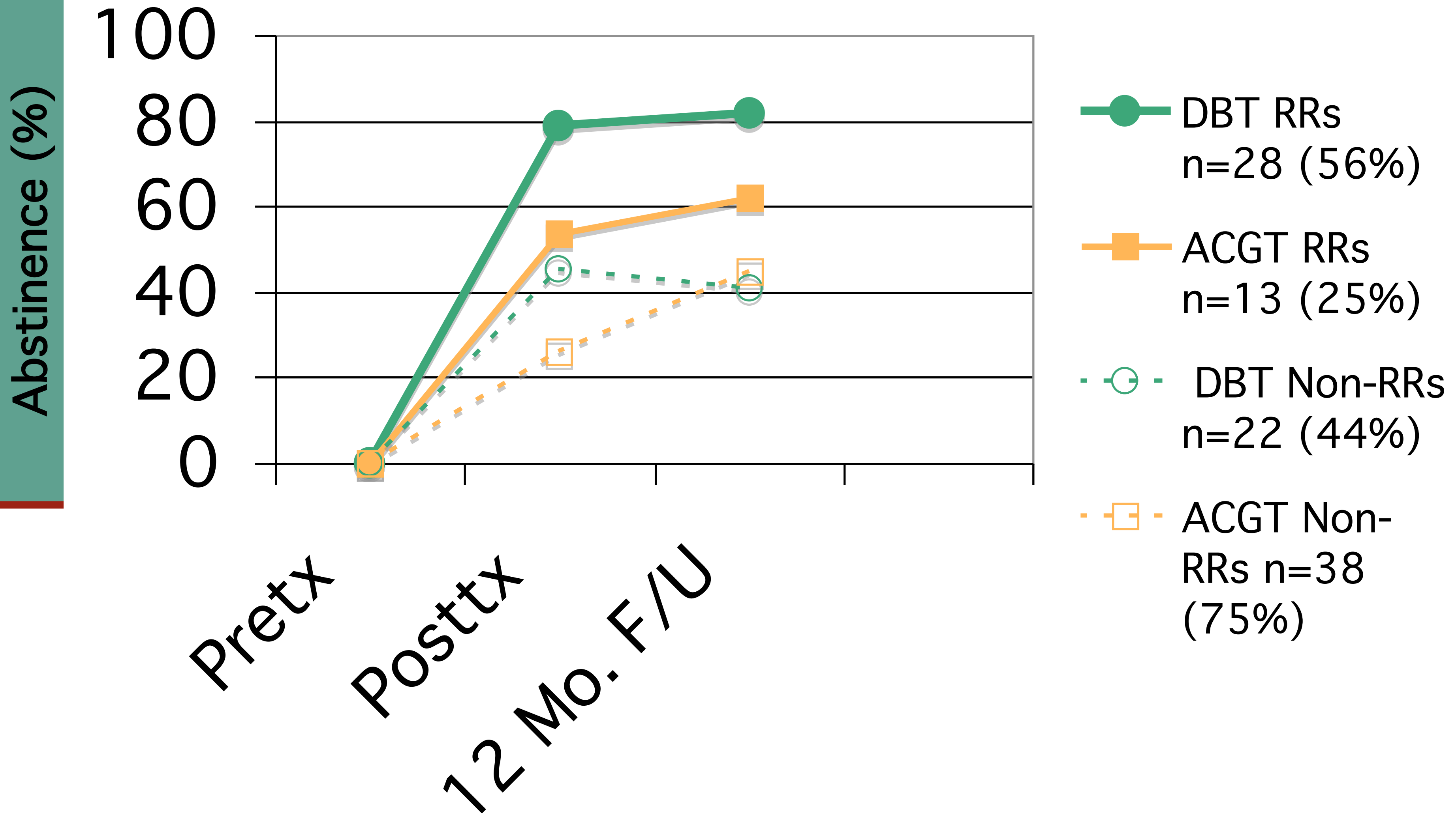


* $p < .05$

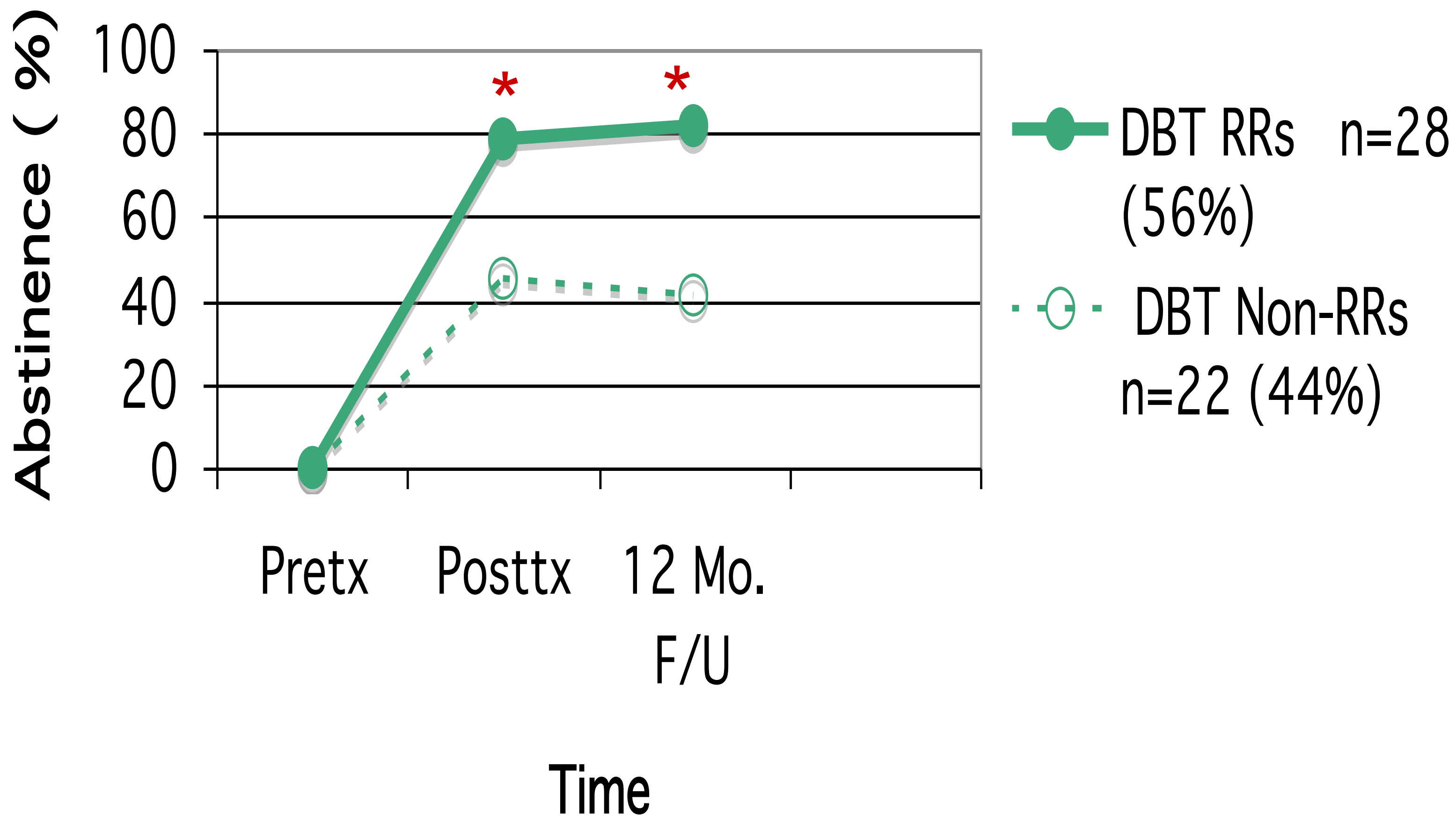
Comparing Abstinence Rates Between Rapid Responders versus Non-Rapid Responders Over Time



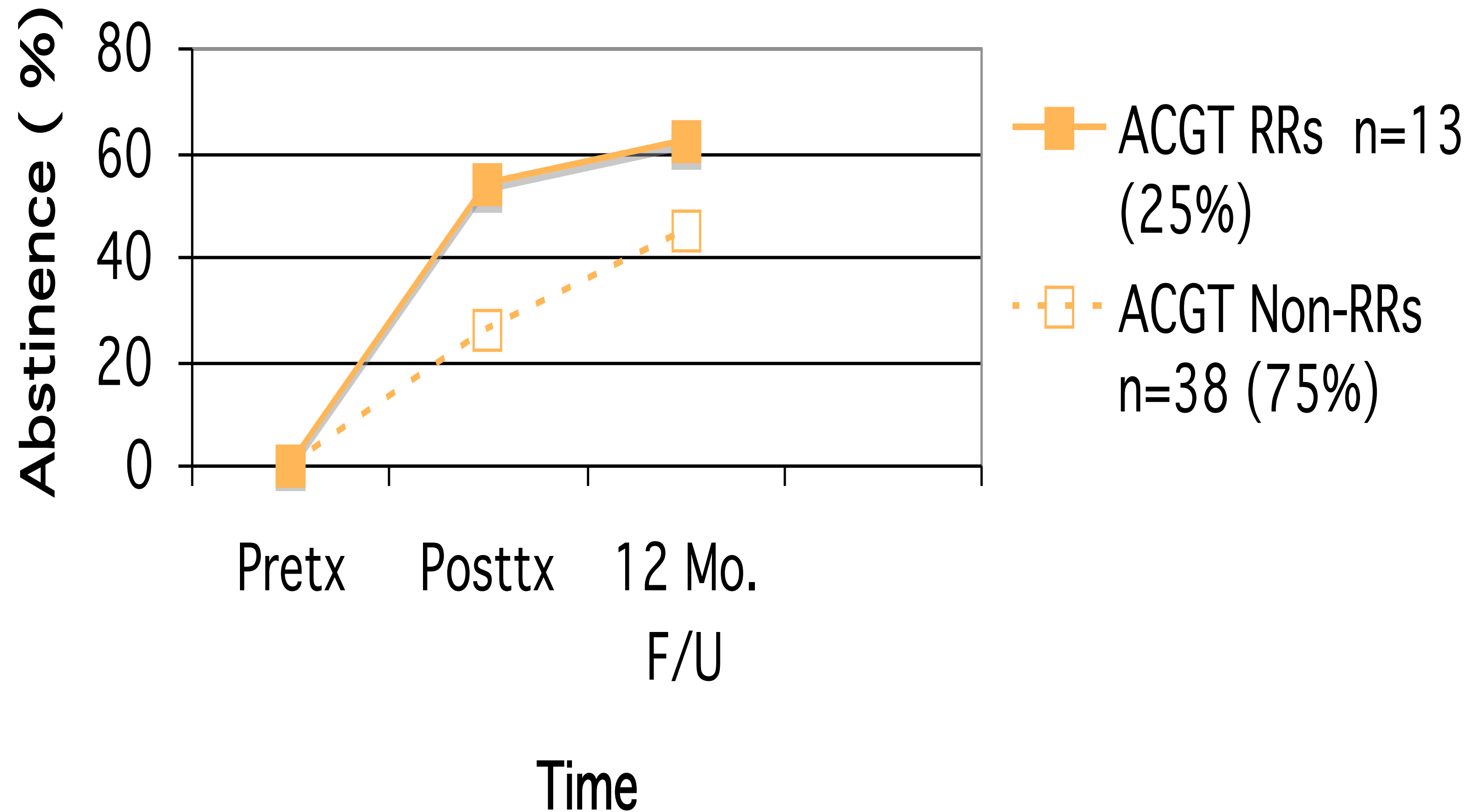
DBT vs ACGT: Abstinence Rates for RRs and Non-RRs Over Time



Rapid Response Predicts Significantly Improved Outcome in DBT Treatment Condition



Rapid Response Does Not Predict Significantly Improved Outcome in ACGT Treatment Condition



Mechanism of Rapid Response: Unknown

- Due to specific changes attributable to particular treatment?
  - e.g., Direct effect of CBT on changing behaviors, cognitions, assigning homework

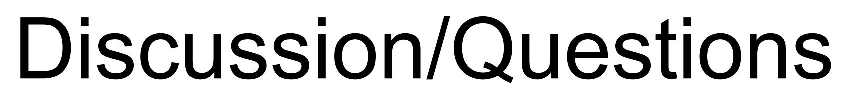
- Due to nonspecific changes common across psychotherapies?
  - e.g., Indirect effects of therapeutic optimism/expectancy, therapeutic alliance, etc.

- If different percentages of Rapid Responders found within different treatment conditions
    - Perhaps RR is mediated by different mechanisms of action (Wilson et al., 1999)

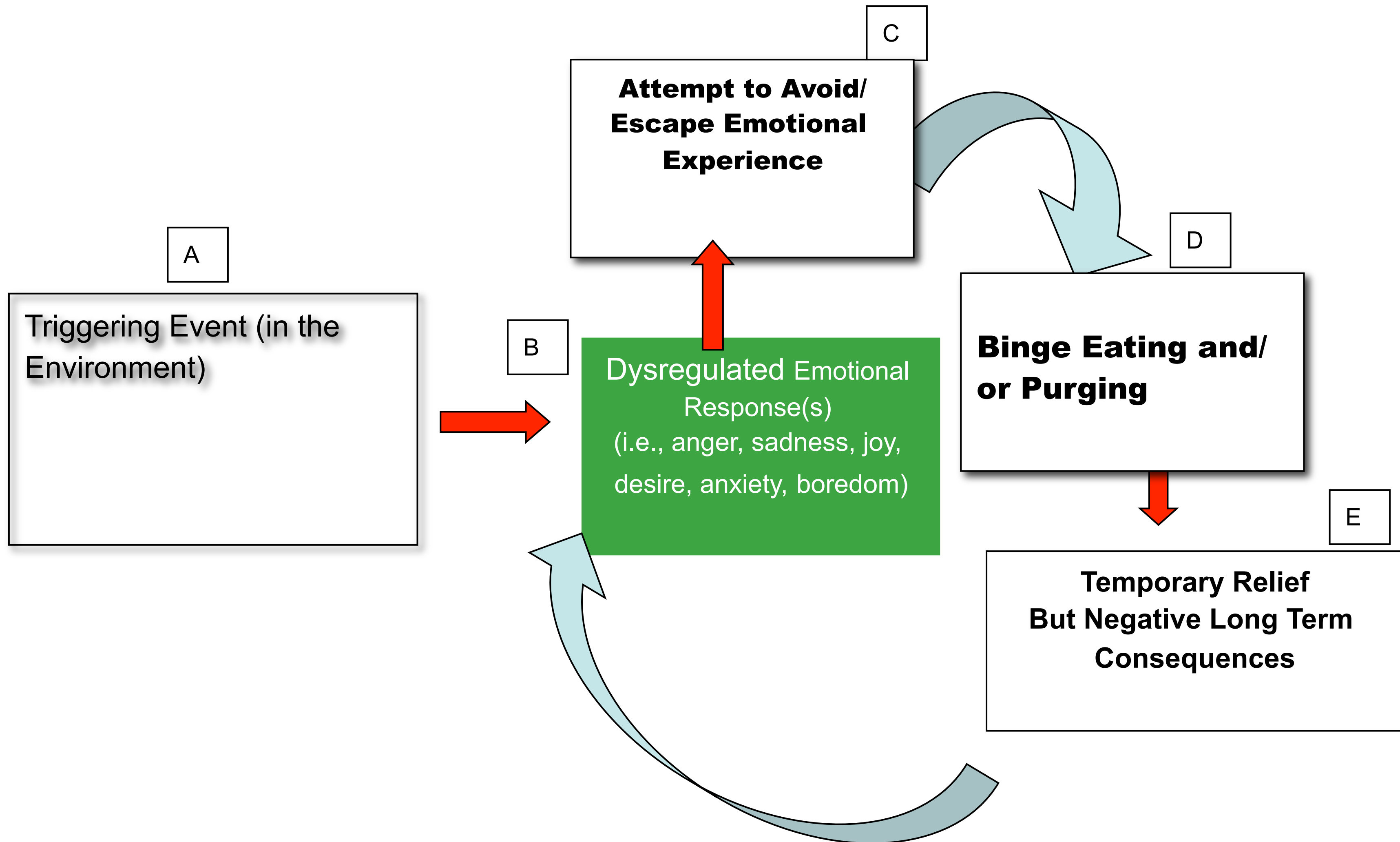
Different Mechanisms of RR?

- In DBT, if a non-RR, chances of improvement relatively small
- However, if a non-RR to ACGT did not significantly predict outcome compared to RR
  - Non-RRs in ACGT showed steady improvements in abstinence rates over the follow-up period
  - Improvements made steadily over time allowed a significant number of ACGT participants to "catch-up"
  - Majority of responders (75%) in ACGT were non-RRs

- May be that the slow, steady gains over time are indicative of a different mechanism of change than that found among rapid responders to an "active" therapy


Discussion/Questions

Affect Regulation Model



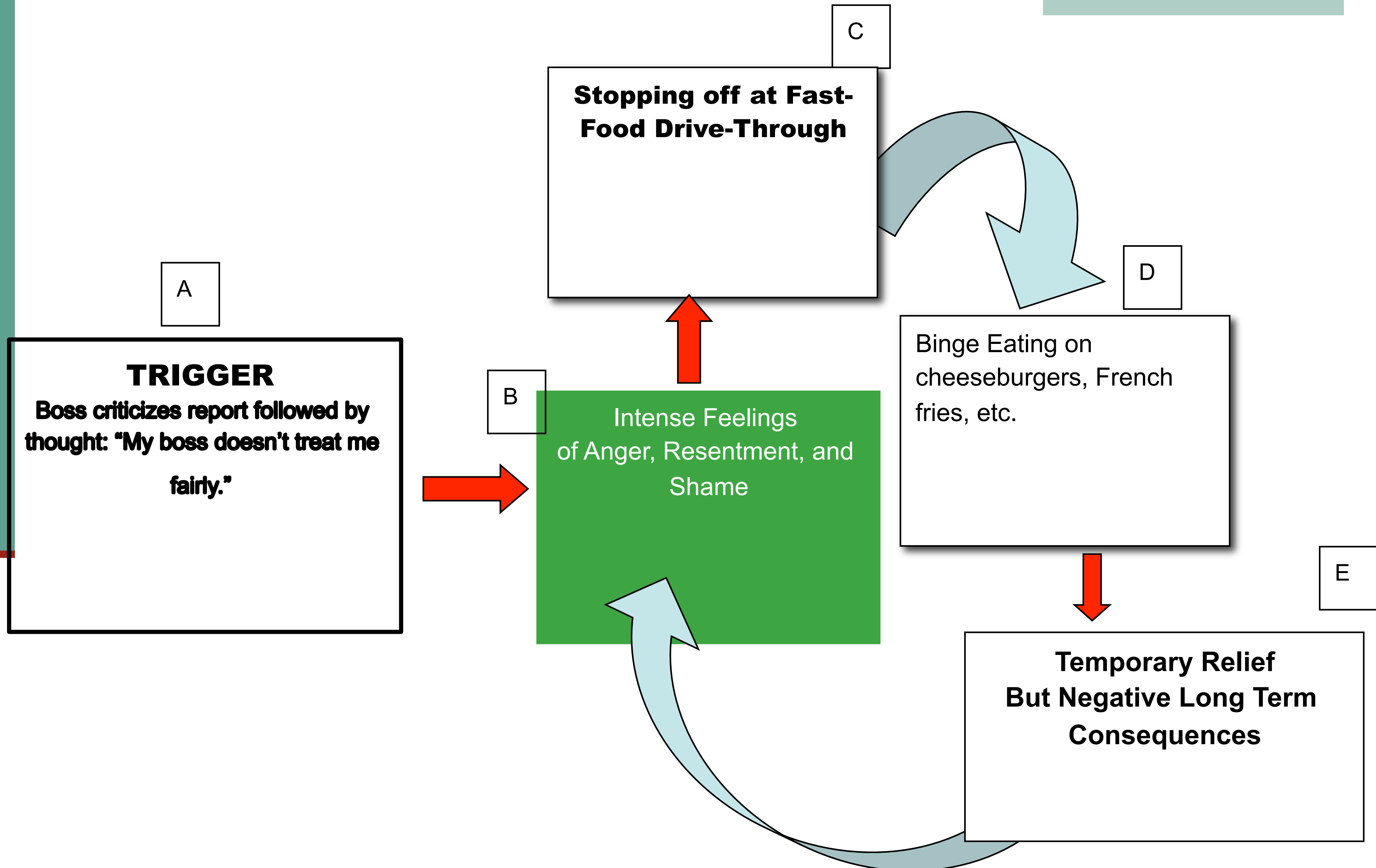
Case Example: Giuseppa

"I was driving home late from work thinking about how my boss made a critical comment about my report. I was so angry—she should have been grateful for how much I did with so little time and with so little help! When I was driving, I saw the McDonalds and felt myself turning the wheel to go into the drive-through. I ordered 2 cheeseburgers, french fries, and 2 apple pies. It tasted good at first. But then, as usual, I started feeling disgusting. How come I keep doing this to myself? Why can't I handle anything? But it didn't end there! After I got home I told myself I wasn't going to have anything else to eat. I really tried to just put things away and then get to sleep—even though I was dreading having to go back to work tomorrow. When I opened the fridge, though, I saw my daughter's leftover birthday cake and it felt like it was all too much. So I finished it so that it would be gone. I always tell myself I'm never doing this again but then I do, and I can't understand why!"

Assessing Buy-In

How would you present the Affect Regulation Model to her to see if it is a good fit?

Affect Regulation Model: Giuseppa



Patients Who Do Not Feel Their Binge Eating is Related to Their Emotions

- Patients may not think that their emotions play a role in their binge eating.
- Or maybe they say to themselves: “I just really love eating” or “ I just eat when I’m bored.”
- Or maybe they don’t know why they overeat.

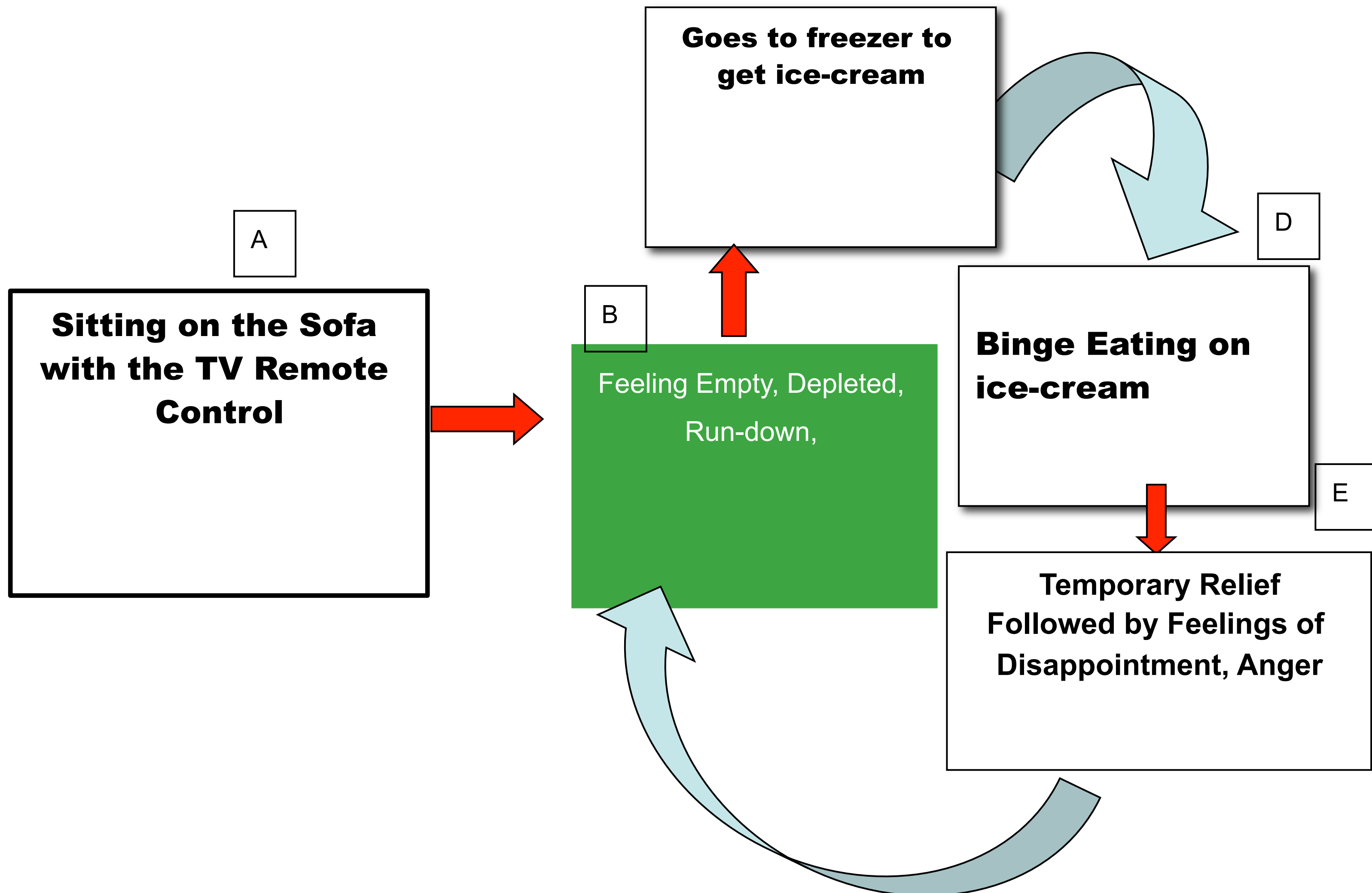
Case History: Giuseppe

Giuseppe, a busy executive with multiple business dinners per week, is distressed by what he thinks of as an irrational habit. Giuseppe reported that after a business dinner, he would arrive home and sit down on the sofa. To relax, he'd turn on the TV. He recalls not feeling hungry, "I just ate dinner," but the next thing he knows he has grabbed a carton of ice-cream and a spoon. He can't identify that anything happened – most days seem pretty much like one another--and he is not aware of feeling anything. He figures that because "nothing is wrong" the binge eating is just a habit he hasn't tried hard enough to stop. He feels he lacks the discipline or willpower to stop. He asks: "I am able to control so many other things in my life, how can I be so terrible at controlling my eating?"

Assessing Buy-In

How would you present the Affect Regulation Model to him to see if it is a good fit?

Affect Regulation Model: Giuseppe



Chain Analysis Exercise

How would you conduct a chain analysis on Giuseppa’s second binge?

ED-Specific Chain Analysis Work-Sheet

What exactly is the Problem Behavior?

What was the Prompting Event?

What things in my myself and my environment made me vulnerable?

Links of Behavior (p.2 of Chain Analysis)

A-Actions
B-Body Sensation
C-Cognitions
E-Events
F-Feelings

		New Skillful Behavior
1	○	
2	○	
3	○	
4	○	
5	○	
6	○	

Chain Analysis Work-Sheet (p. 3)

What were the CONSEQUENCES?

(short term)
(longer term)

Ways to reduce my VULNERABILITY in the future? .

Plans to REPAIR, CORRECT, and OVER CORRECT

My deepest thoughts and feelings about this

Possible Questions to Ask

Patient: I was driving home late from work thinking about how my boss made a critical comment about my report…

Therapist:

Patient*:* When I was driving, I saw the McDonalds and felt myself turning the wheel to go into the drive-through.

Therapist:

Patient: Not really—I felt compelled, almost mindless. I ordered 2 cheeseburgers, fries,

Therapist:

Possible Questions to Ask

Patient: I was driving home late from work thinking about how my boss made a critical comment about my report…

Therapist: **So it sounds like you were feeling really angry? Anything else (hurt, resentful?)**

P: When I was driving, I saw the McDonalds and felt myself turning the wheel to go into the drive-through.

Therapist: **You said you felt yourself turning the wheel—so you felt aware of what you were doing?**

P: Not really—I felt compelled, almost mindless. I ordered 2 cheeseburgers, fries,

Therapist: **Can you say more about how you were feeling as you ate? [Do you think you were still thinking about what had happened at work?]**

Possible Questions to Ask (continued)

P: I just ate. Nothing seemed to matter much. But soon I felt horrible.
T:

P: I got home.
T:

P: I told myself I wasn't going to have anything else to eat. I really tried to just put things away and then get to sleep—even though I was dreading having to go back to work the next day.
T:

P: Yes. And when I opened the fridge I saw my son's leftover birthday cake and it felt like it was all too much.
T:

P: So I finished it so that it would be gone. I always tell myself I'm never doing this again but then I do, and I can't understand why!"

Questions to Ask (continued)

P: I just ate. Nothing seemed to matter much. But soon I felt horrible.
T: So then what happened?
P: I got home.
T: How do you think you were feeling then?
P: I told myself I wasn't going to have anything else to eat. I really tried to just put things away and then get to sleep—even though I was dreading having to go back to work the next day.
T: So you remained downstairs in the kitchen?
P: Yes. And when I opened the fridge I saw my son's leftover birthday cake and it felt like it was all too much.
T: So you were thinking it felt like it was all too much. Any emotions? [overwhelmed, self-pity]
P: So I finished it so that it would be gone. I always tell myself I'm never doing this again but then I do, and I can't understand why!"

How would you present this the emotion regulation model to her to assess if it is a good fit?

DBT-BED and DBT-BN Common Challenges

- Difficulties conducting treatment using group format
- Structuring homework review
- Obtaining group commitment to abstinence

Challenges to Maintaining Structure of First Half of Session

- Time constraints
  - Very clear directions at outset
    - 5 minutes per person (co-therapist monitors)
    - "Read directly from chain"
    - Continued shaping
- Therapy Interfering Behavior (e.g. not completing homework)
  - **Those without completed homework share last**
  - Unclear understanding of behavioral principles (want to describe a whole week of binge eating/purging, not one episode)
    - Begin by stating problem behavior

Structuring Homework Review

Skills Taught Thus Far: (1) Practicing the commitment (2) 3X5 card (3) Filling out diary card and chain analysis

1. Did you have a binge? Purge?
2. Did you practice the skills?
   a. If no, what got in the way?
   b. If yes, what worked?
3. Did you fill out your diary card and chain analysis?
   a. If not, what got in the way?
   b. If yes,
      i. What was the problem behavior?
      ii. What was the dysfunctional link?

Conclusions

- DBT as adapted for BED and BN has shown promising results in preliminary findings
- More research needed
  - Generalize results to other populations and treatment settings
  - Improve maintenance of abstinence
  - Compare DBT to other leading active treatments (e.g., CBT, IPT)

Ask about the Pros/Cons of Binge Eating and/or Purging

Questions?

Mental Simulation/Planning Ahead

- Experiential Exercise