Dialectical Behavior Therapy

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Barent W. Walsh and Jennifer E. Eaton

Abstract

This chapter reviews the basics of Dialectical Behavior Therapy (DBT) as applied in the treatment of co-occurring non-suicidal self-injury (NSSI) and eating disorders (ED). The four major components of DBT are discussed including individual treatment, group skills training, skills coaching between sessions, and the consultation team for treaters. Modifications to the original form of DBT are reviewed including an outpatient application for adolescents who present with suicidality and NSSI and another outpatient version for adults who present with bulimia and binge eating. A detailed case example is employed demonstrating the specific interventions of DBT for the interrelated problems of NSSI and ED.

8.1 Introduction

Dialectical Behavior Therapy (DBT) is an especially relevant treatment for non-suicidal self-injury (NSSI) and eating disorders (ED) for at least three reasons: (1) the problems of NSSI and ED frequently co-occur (Muehlenkamp, Claes, Smits, Peat, & Vandereycken, 2011; Svirko & Hawton, 2007; Chap. 1 Claes & Muehlenkamp, 2013); (2) the behaviors share the common characteristic of recurrent, painful, pervasive emotion dysregulation (Claes, Klonsky, Muehlenkamp, Kuppens, & Vandereycken, 2010; Linehan, 1993a; Muehlenkamp, Peat, Claes, & Smits, 2012); and (3) DBT has been shown to be an effective, empirically based treatment for NSSI (e.g., Miller, Rathaus, & Linehan, 2007; van den Bosch, Koeter, Stijnen, Verheul, & van den Brink, 2005; Walsh, Doerfler, & Millner-Hanley, 2012) and some eating disorders, most notably binge eating and bulimia nervosa (Safer, Robinson, & Jo, 2010; Safer, Telch, & Chen, 2009; Telch, Agras, &

B.W. Walsh (✉) • J.E. Eaton
The Bridge of Central Massachusetts, Worcester, MA, USA
e-mail: barryw@thebridgecm.org

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Linehan, 2001). To date, most evaluations of DBT have focused either on NSSI or eating disorders, rather than both in combination. Such is the contribution of this volume that the two problems are discussed at length in combination with an emphasis on successful treatment recommendations.

8.2 What Is Dialectical Behavior Therapy?

DBT is an empirically validated, cognitive-behavioral treatment, informed by the mindfulness practices of Zen Buddhism. It has four major components: (1) weekly, highly structured individual therapy (using a hierarchy of behavioral targets and diary cards), (2) weekly group skills training that focuses on four major skill areas (mindfulness, distress tolerance, emotion regulation, and interpersonal effectiveness), (3) coaching by the therapist or other treaters between sessions to assist clients with skill acquisition and generalization to the environment, and (4) a weekly consultation meeting for the treatment team, designed to enhance learning of DBT and to provide peer support and supervision. These modes of treatment are designed to teach self-destructive and self-defeating clients to employ healthier emotion regulation and interpersonal skills and thereby achieve a new, improved, "life worth living" (Linehan, 1993a, 1993b). Via the consultation team, the treatment is also designed to "treat the treaters," a phenomenon that may be unique to DBT. The team is designed to reduce caregiver burnout and enhance therapists' skills.

As suggested by the above list of core components, DBT is a complex, intensive, and comprehensive treatment that is not meant for everybody. People with minor, short-lived histories of NSSI and ED may not require a treatment as complex and multimodal as DBT. However, for those with persistent, serious NSSI and ED, DBT may well be a treatment of choice.

DBT was originally developed as a treatment for adult women with borderline personality disorder who presented with pervasive emotion dysregulation, suicidal behavior, non-suicidal self-injury, and other problems such as frequent psychiatric hospitalizations (Linehan, 1993a, 1993b). In its original form, DBT was delivered on an outpatient basis via weekly individual therapy sessions in combination with weekly group skills trainings. Completing the treatment generally took about one year.

8.3 Modifications to the Original DBT

In the 20 years since the publication of Linehan's seminal work (1993a, 1993b), DBT has been repeatedly modified in terms of number of sessions provided, specific skills taught, client populations served, and clinical problems addressed. For example, Miller et al. (2007) developed an empirically validated version of DBT for suicidal and self-injuring adolescents that (1) reduced the length of the treatment from one year to 16 weeks (with the possibility of 16-week "graduate

group" extensions); (2) incorporated at least one family member, most often a parent, into group skills training; (3) introduced a fifth skills training module, named "Walking the Middle Path"; and (4) modified skills training lectures, handouts, and diary cards, based on the developmental characteristics and learning styles of adolescent clients.

In a similar vein, Safer et al. (2009) have described in book-length detail a modification of DBT for individuals with binge eating and bulimia nervosa. Their version of DBT has been endorsed by Linehan and is delivered in 20 weekly sessions including a 2-h group format for binge-eating disorder clients or a 1-h individual format for those with bulimia (Safer et al., 2009). In addition, their modified versions include three of the original four skills training modules (mindfulness, emotion regulation, distress tolerance). Their rationale for excluding DBT's interpersonal effectiveness module is "based on clinical trial design concerns regarding potential overlap with other treatments developed for binge-eating disorder or bulimia nervosa that specifically focus upon treating interpersonal problems" (Safer et al., 2009, p. 2). Worth noting is that the authors recommend utilizing standard, comprehensive DBT (i.e., Linehan, 1993a, 1993b) if additional target behaviors need to be addressed including suicidal behavior, NSSI, and substance abuse or if the client has a comorbid mood disorder or personality disorder (Safer et al., 2009, p. 2–3). Since this chapter is targeting NSSI in conjunction with eating disorders, the standard, comprehensive version of DBT will be utilized for discussion purposes.

To date the large majority of studies evaluating DBT interventions for eating disorders have focused on binge eating and bulimia (e.g., Robinson & Safer, 2012; Safer et al., 2009, Safer, Lively, Telch, & Agras, 2002, 2009) and not on anorexia nervosa. Only recently have DBT researchers turned their attention to evaluating interventions with anorexia nervosa (e.g., Safer, 2011; Safer, Darcy, & Lock, 2011). As an indication of the dearth of studies pertaining to the treatment of anorexia, Safer noted, "At present no evidence-based treatments are available for adults with anorexia nervosa" (Safer, 2011, p. 203). Fortunately, DBT can be said to be an evidence-based treatment for NSSI and for binge-eating disorder and bulimia nervosa.

8.4 Treating NSSI and Eating Disorders with DBT

As noted above, DBT has four components: (1) individual therapy, (2) group skills training, (3) skills coaching between sessions, and (4) a consultation team for treaters. The remainder of the chapter will review these components with attention to how the DBT can treat NSSI and ED simultaneously in an interrelated fashion.

8.4.1 Individual Treatment with DBT

Individual treatment in DBT is the core modality, the anchor for the treatment. The philosophy central to DBT is that the therapist must strategically balance validation with change. The importance of validation in working with clients with the combined problems of NSSI and ED cannot be overstated. As noted by Muehlenkamp et al. (2011), variables with empirical links to the relationship between NSSI and ED include childhood trauma, dissociation, affective disorders, body dissatisfaction, self-criticism and self-derogation, and especially problems with affect dysregulation. Individuals who struggle with both NSSI and ED are generally exceptionally vulnerable individuals who need a great deal of support to initiate and remain in treatment. Many have endured mistreatment in family relationships and are distrustful and wary. Facilitating behavioral change in a therapeutic environment requires a finely tuned and sensitive ability to validate. DBT places so much emphasis on validation that it articulates six different levels. These range from the simplest form of paying attention (while using basic verbal and nonverbal cues) to normalizing self-destructive behaviors (as understandable attempts to regulate emotion distress) to its most advanced form of treating clients with genuine respect as coequals in a shared project (Linehan, 1993a). With this dialectic of balancing validation and change as the bedrock for the treatment, three additional core components of individual therapy are the use of (1) the DBT hierarchy of targets, (2) diary cards, and (3) chain and solution analyses.

8.4.1.1 DBT Hierarchy of Targets

The DBT targets provide a hierarchy with which to address problems within the treatment. The DBT targets in order of importance are (1) decreasing life-threatening behaviors, (2) decreasing therapy-interfering behaviors, (3) decreasing quality of life-interfering behaviors, and (4) increasing the use of new behavioral skills. The DBT hierarchy provides a way to prioritize target behaviors within the treatment. Individuals with NSSI and ED often have multiple problems they need to address. For example, an individual may complain about having suicidal urges several times a month, cutting herself several times per week, binge eating followed by inducing vomiting several times per week, having frequent conflicts with significant others and work colleagues, and finding it difficult to attend therapy twice a week (individual and group). The DBT targets provide a way to organize and prioritize these diverse problems into a manageable list. More specifically, using the list of problems just reviewed, the therapy might identify the following targets:

- Decreasing life-threatening behaviors
  - Priority # 1: Suicidal urges (due to potential lethality)
  - Priority # 2: Cutting (due to empirical link with suicide attempts long term)
- Decreasing therapy-interfering behaviors
  - Priority # 3: Finding it difficult to get to therapy appointments (without treatment, positive change is unlikely)
- Decreasing quality of life-interfering behaviors

- Priority # 4: Binge eating and purging (due to health concerns, risk of unstable vitals, damage to esophagus, tooth enamel, etc.)
- Priority # 5: Frequent conflicts with significant others and colleagues (important but neither is life threatening nor health compromising)

- Increasing the use of new behavioral skills
  - Increasing use of skills learned in individual therapy and group skills training (ongoing)

In addition to prioritizing targets, the DBT hierarchy provides a basic structure to the treatment. Each session begins with a review of the targets and related homework. This structure provides predictability and containment. It also establishes some order in what might otherwise be experienced as chaotic and overwhelming. The message is: "First we'll work together on this primary target and when that has been neutralized, we'll move on to the next, and then the next. All of this will occur as you acquire, practice, and use many new helpful skills."

8.4.1.2 Diary Cards

Diary cards are reviewed at the beginning of every individual therapy session. Diary cards are self-monitoring tools to track the individual DBT targets and emotions daily, set the agenda for the individual therapy sessions, monitor skills practiced over the past week, and assess changes/trends over time (Linehan, 1993a; Miller et al., 2007; Safer et al., 2009). If a client fails to bring his or her diary card to session, the client is asked to complete it at the beginning of the session. Diary cards are emphasized as a key part of homework, and failure to complete them is deemed a "therapy-interfering behavior." The therapist addresses any non-completion quite directly in an assertive, yet validating way. The justification is that "the clients who do the most homework are likely to get the most benefit." Consistent with this principle, the therapist routinely will conduct a chain analysis (see below) to explore obstacles interfering with diary card completion and to identify potential solutions moving forward.

Figure 8.1 presents a sample diary card for Sharon, a 32-year-old mother of three who has the following DBT targets:

1. Decreasing life-threatening behaviors

   Priority #1: Sharon experiences occasional suicidal urges but has never attempted or had a specific plan. She is especially triggered after binge-eating episodes due to related self-loathing.

   Priority # 2: Sharon presents with cutting behavior 2–3 times per month. The cutting involves tissue damage to her arms and legs, but it has never required medical attention.

2. Decreasing therapy-interfering behaviors

   These are not a problem for this client. She consistently attends individual therapy and skills group and completes homework.

3. Decreasing quality of life-interfering behaviors

   Priority # 3: Sharon has been diagnosed with eating disorder, NOS due to her binge eating. Her primary care MD is concerned about her weight gain of 50 lb, elevated blood pressure, and borderline risk for diabetes. She reports

DIARY CARD **Initials: SB** **Date:** ___________ Filled out in session? Yes / **No** / Maybe How often did you complete? **Daily** / 2-3 times per week / Once / Other :______
Went to Group? **Yes** / No

	Suicidal Behavior		Self-Injury		Binge Eating			Meals				Emotions									Skills used, or lack thereof	
	Urges/ Thoughts	Actions	Urges/ Thoughts	Actions	Urges	Actions	Binge encour-aging behaviors	Breakfast	Lunch	Dinner	Snacks	Bored	Anger	Fear/ Anxiety	Joy	Misery	Physical pain	Sad	Shame	Guilt		
Date	*0-5*	*Yes/no*	*0-5*	*Yes/No*	*0-5*	*Yes/no*	*Describe*	*Detail food items and amounts*				*0-5*									*0-5*	*What Skills?*
Th	1	n	0	n	3	n	Walked down cookie aisle	2 eggs, toast (2), coffee	Turkey sandwich, baked potato chips-indiv bag	6 oz Chicken, rice pilaf-1c, broccoli, 1.5 cups	Apple, banana w/ PB	2	1	0	1	2	0	0	2	2	4	Scrap-booking, park w/kids
F	2	n	5	Cut 3 x on arm	3	n	n	Cereal, coffee	Tuna sandwich, small bag of chips	6 oz broiled fish, 1.5 cup beans	Tangerine, PB crackers	0	2	5	0	4	0	3	4 after ward s	4	1	Failed to use skills
Sa	1	n	1	n	5	y	Went to McDonalds for lunch	3 Scrambled eggs with coffee	5 big macs 2 large fries	Nothing	Apple in morning, nothing afterwards	0	1	3	0	4	0	5	5 after	5 after	3	Used breathing in morning and evening but not around lunch time
Su																						
Mo																						
Tu																						
W																						

Target Behaviors:
0=not at all
1=a bit
2=somewhat strong
3=rather strong
4=strong
5=very strong

Notes:

Used Skills Key:
0= didn't use skills, didn't even consider
1= thought about, didn't use skills
2= used skills, didn't work
3= used skills, partly worked
4= used skills, didn't work then did work
5= used skills, worked, success!

Fig. 8.1 Diary card

binge eating 2–4 times per week. While her binge eating is certainly concerning, it does not meet DBT criteria for "life threatening." At present her eating disorder does not pose risk to life and she has no suicidal intent in relation to it.

Priority # 4: She identifies that she is less sexually active with her husband due to self-consciousness regarding weight. She is also sexually avoidant when her wounds from cutting are fresh.

Priority # 5: She at times feels frustrated being a stay-at-home mom with little contact with fellow adults.

4. Increasing the use of new behavioral skills

   Sharon has begun actively working on skills including scrapbooking (which she finds calming); breathing mindfully; attending a gym—where she has a personal trainer; and walking which she finds relaxing and mood enhancing. Sharon has also started practicing mindful eating.

   Sharon comes from a family that she describes as large and chaotic. She is 1 of 7 siblings, the oldest of whom molested her from the ages of 9–12. She says that her childhood was massively invalidating in that her mother was often depressed and unavailable and Sharon was forced to be a primary caregiver for younger siblings. In addition, the greatest invalidation occurred when she disclosed her brother's molestation to her mother and the mother's response was to call her "a liar" and "ground" her as punishment.

The client identifies her greatest problem as her binge eating. She is self-loathing regarding her weight gain and notes that she feels suicidal primarily after binge-eating episodes due to her self-disgust. She is also concerned about her cutting behavior and is especially worried her children may notice her wounds and scars. She believes that her self-injury is usually an attempt to avoid binge eating in that both provide a self-soothing effect. However, she concedes she finds binge eating much more "gratifying" than cutting. She also concedes, "With me, it seems to be one or the other. I can never get a handle on both."

As shown in Fig. 8.1, the sample (partially completed) diary card provides a great deal of information about Sharon's DBT targets, eating plan, emotions, and skills practice in a concise format. The top panel indicates that Sharon completed her diary card daily and attended group. The information contained on the row labeled "Thursday" shows that she had a successful day in avoiding suicidal urges, self-injury, binge eating, and following her meal plan. Her emotions were at a rather low level of 2 out of 5 (see key at the bottom of the diary card), and her skills practice was effective (4 out of 5) including scrapbooking and going for a walk to the park with her children. The day labeled Friday was less successful. She cut herself three times apparently related to emotions of fear/anxiety (rating of 5) and misery (4). In addition, she reported feeling shame (4) and guilt (4) after her cutting. Not surprisingly, she reported that she failed to use her skills on the day she cut herself.

A similar pattern emerged on Saturday, when Sharon left the children in the care of their father while she went to "do some errands." This led to a binge-eating episode at McDonald's which was linked to overwhelming feelings of sadness (5)

and misery (4). Moreover, after the episode she felt intense guilt (5) and shame (5). And again not surprisingly, Sharon's skills practice was rather weak on Saturday. She had attempted to do some mindful breathing in the morning but failed to use other skills as the binge-eating episode unfolded.

8.4.1.3 Chain Analysis

The next step in the DBT individual therapy process is to conduct a chain analysis of the target behavior with the client. A chain analysis provides a very detailed snapshot of a specific incident such as Sharon's binge eating at McDonald's. This careful, meticulous behavioral analysis enables the client to understand why the behavior occurred. In addition, multiple chains over time uncover recurrent patterns of behavior that can be targeted, moving towards what DBT calls "solution analysis" (Linehan, 1993a). The basic components of a chain analysis in DBT are (1) exploring vulnerabilities, (2) identifying prompting event(s), (3) exploring thoughts and feelings (links), (4) identifying the problem behavior(s), (5) exploring more thoughts and feelings (links), (6) identifying consequences (both pro and con), and (7) performing a solution analysis (i.e., identifying alternative solutions (new links)) (Linehan, 1993a). It should be noted that more elaborate versions of chain analysis have recently been articulated (see Safer et al., 2009, p. 78).

Using Sharon as an ongoing example, we will describe a chain analysis regarding her binge-eating episode (in Sharon's own words) that she completed with her therapist in session:

1. Exploring vulnerabilities: I was feeling tired after two nights of poor sleep. The cutting was a sure sign I was in trouble. I have an 8-year history of binge eating. It's my toughest problem.
2. Identifying prompting event(s): It's springtime and the weather is warming. I had taken out some summer clothes and found they did not fit.
3. Exploring thoughts and feelings (links): Thoughts were, "It's hopeless; I'll never lose weight; Age is working against me; I'm a fat cow." Feelings were hopeless, sadness, and shame.
4. Identifying the problem behavior(s): Telling my family I was going to do errands and then going to McDonald's, buying lots of food, and binge eating in my car.
5. Exploring more thoughts and feelings (links): More thoughts: "If it's hopeless, I might as well do what I do best, eat like a pig." "I'm such a loser, I even cut myself yesterday." Feelings: Even more intense sadness, shame, and hopelessness.
6. Identify consequences (both pro and con): Short-term pro: I felt some satisfaction from the good taste and being really full. Short-term con: Almost immediately afterwards, I felt nauseous plus shame and revulsion. Long-term con: continued weight gain, hatred for my body, risks to health, and less sex with my husband. And I had suicidal urges after bingeing.
7. Solution analysis: Identify alternative solutions (new links); I could have called my therapist for skills coaching. I could have used my breathing and walking skills to calm down after trying on clothes. I could have identified my thoughts

about the hopelessness of losing weight as negative and pessimistic. I could have taken my family with me to "do errands" which would have prevented the binge eating at McDonald's.

8.5 Group Skills Training

Group skills training is the other weekly modality in DBT. The expectation is that DBT groups have a leader and a coleader intensively trained in DBT. Ideally, the group leaders are not the individual therapist for any of the clients within the group; however, in practice this is not always possible. Many skills group operate with a structure like the following:

- The group begins with a brief mindfulness exercise such as relaxing breathing or a visualization.
- Members present a review of their skills practice during the past week (hopefully daily).
- Members describe the use of skills that proved successful.
- Members describe any difficulty in practicing a skill and the leaders and group members provide assistance and problem solving.
- The new skill of the week from the DBT manual (Linehan, 1993b) is then taught, modeled, and practiced. Activities and role plays are often used to enhance learning.
- Homework regarding the new skill is agreed on for the coming week.
- A concluding mindfulness activity brings the session to a close.

One caveat that is important to emphasize in delivering group treatment is that social contagion can be a major risk with individuals who present with NSSI (Linehan, 1993a; Walsh, 2012) and/or ED (Becker, Smith, & Ciao, 2005; Crandall, 1988). More specifically, when group members with NSSI and ED are exposed to detailed discussions of self-injury and/or eating disorder behaviors, they can often be triggered into relapse or exacerbation of symptoms. As a result, a key rule in providing DBT skills training groups is that clients commit not to talk in detail about NSSI or ED within the group. The explanation to group members is that discussing NSSI and ED behaviors in groups has been shown empirically to trigger the behaviors in others (Becker et al., 2005; Crandall, 1988; Walsh, 2012). Groups therefore are for teaching and practicing skills rather than discussing NSSI or ED. Individual therapy is where clients should discuss their NSSI and ED in great detail using their diary cards and chain analyses. Walsh and colleagues (2012) have shown that sticking to this principle in providing skills training groups can successfully avoid self-injury contagion in a group home for adolescents. Similar beneficial effects can be expected regarding the management of eating disorders. However, worth noting is that Safer and colleagues (2009) recommend conducting chain analyses in group when treating binge eating and bulimia. Skillful group leaders may well be able to handle such activities, but they should also be alert that the risks of social contagion are considerable.

As noted above, DBT teaches four skill modules in weekly group sessions: (1) core mindfulness, (2) distress tolerance, (3) emotion regulation, and (4) interpersonal effectiveness. These are taught step by step using the DBT skills manual (Linehan, 1993b) or other modified versions (e.g., Miller et al., 2007; Safer et al., 2009). The four skills will be discussed in order with reference to their utility with NSSI and ED problems.

8.5.1 Core Mindfulness

Mindfulness has been defined as "full awareness in the present moment without judgment" (Germer, Siegel, & Fulton, 2005). Mindfulness has the potential to offer considerable solace to those who present with NSSI and ED because it offers a specific antidote to suffering. To explain this potential for relief, it is necessary to "unpack" the definition from Germer and colleagues. Let's take "full awareness" first. Full awareness is the opposite of multitasking, distractibility, or chaos. Full awareness is focusing on only one activity at a time with full attention. This can involve pretty much any activity such as doing the dishes, or completing one's diary card, or talking with a colleague, or listening to the music, or meditating. Moreover, full awareness is grounded in the present moment. This is often a significant narrowing of focus for clients; it means they are not consumed with the past (and what frequently involves many defeats or traumas), nor are they anticipating the future (and what may be perceived as daunting, insurmountable challenges). In focusing on the present moment, mindfulness takes a break, a vacation, from past and present. In addition, this focused attention proceeds without judgment. This means the individual suspends judgment of both self and others. Suspending judgment can be no small liberation for those with NSSI and ED as they are prone to self-denigration (Muehlenkamp et al., 2011) and may be similarly critical of caregivers and significant others.

There are six mindfulness skills taught in DBT: the "what" skills of observe, describe, and participate and "how" skills of nonjudgmentally, one-mindfully, and effectively. A goal is for clients to learn that negative emotions are not steady states or permanent realities. Rather, they learn that emotions come and go and can be markedly influenced. Clients learn to step back, observe, discuss, and manage their emotions effectively, while keeping their focus on their goals. DBT uses a host of metaphors to teach new ways to manage pervasive emotion dysregulation, such as moving from "Velcro mind" where every negative emotion "sticks" and "clings" to "Teflon mind" where problems are acknowledged but allowed to "slip and slide away."

Put another way, DBT mindfulness skills emphasize clients moving away from being dominated by emotion mind (e.g., intense anxiety, shame, rage, depression) into wise mind which is a centered synthesis of reasonable mind and emotion mind (Linehan, 1993a, 1993b). All of us are in wise mind some of the time; these are the moments when we are fully in touch with our emotions but are also grounded in

making wise, focused decisions in our best interest. A goal is to cultivate wise mind through practice, practice, practice. A favorite method for practicing mindfulness is through guided breathing exercises which have been shown to reduce heart and respiration rate and blood pressure (Walsh, 2012). These can be especially useful in fending off urges to self-injury.

Another form of mindfulness that can be a great match for ED problems includes mindful eating. This skill applies full awareness in the present moment without judgment to eating. It serves to counteract automatic, mindless, or rushed ingestion that often characterizes binge eating. It involves slowing down and applying full attention to the appearance, texture, smell, and taste of food.

"Alternate rebellion" is an addition to the original mindfulness module (McMain, Sayrs, Dimeff, & Linehan, 2007). It acknowledges that some NSSI or ED may be intended to "take revenge" on others who have mistreated them or judged their self-injury, appearance, weight, or eating. This skill recommends "rebelling" in a safer, more effective way such as using verbal assertiveness rather than cutting or binge eating.

In returning to the discussion of Sharon, she found it helpful to apply mindful eating to her daily life. At mealtime, especially when alone, she began eating "one-mindfully" at the dining room table rather than in front of the television or when driving. She also served herself measureable portions rather than bringing an entire large bag of chips to the table. Sharon found it helpful to become less judgmental regarding her eating and body image.

8.5.2 Distress Tolerance Skills

Distress tolerance skills help clients endure uncomfortable emotions without resorting automatically to NSSI and ED behaviors or other self-defeating acts. One of the metaphors used in DBT to teach distress tolerance skills is learning to "sit with the pain." This involves watching emotional pain ebb and flow, rather than grasping on to it which results in sustained suffering. Another metaphor is learning to "surf the urge" to self-injure or binge eat or purge or restrict. In DBT, clients learn that these urges are not irresistible, all-powerful, or permanent; rather, they are time limited and vacillating and will dissipate if one learns to "tolerate the distress."

Particularly important for Sharon was to combine her mindful breathing skills with urge surfing—which is an addition to the original distress tolerance module (McMain et al., 2007). Sharon found "breathing through her urges" particularly helpful in not submitting to intense food cravings or thoughts of cutting. A special benefit was that she was able to use this skill anywhere while "on the go."

Distress tolerance skills include both crisis survival skills and acceptance skills. Crisis survival skills help clients learn to manage crises and interrupt automatic patterns of NSSI and/or ED. Specific skills include learning to distract oneself by focusing on another activity (such as watching a movie, or shopping, or doing a crossword), self-soothe (using one's senses in a calming way such as taking a bath,

listening to peaceful music), IMPROVE the moment, (an acronym for seven self-management skills including calming imagery and relaxation strategies), and conducting a pros and cons (i.e., a thorough, honest analysis of the advantages and disadvantages of proceeding with NSSI or ED behaviors).

The pros and cons skill helps clients to manage emotion mind by stepping back and using observe and describe skills in considering potential outcomes before engaging in a behavior. The act of thinking about pros and cons can interrupt the link between experiencing an urge and acting on that urge. When pros and cons seem too difficult to employ, the urge surfing skill or a mindful breathing exercise can be helpful.

A brief example of a pros and cons exercise was provided above in Sharon's chain analysis of her binge-eating episode. However, had she conducted the pros and cons exercise before her binge eating, she might have been able to avoid it. Her analysis clearly showed that the cons for binge eating much outweighed the pros. Clients often carry their pros and cons lists with them to remind them of the negative consequences of a self-harm behavior. In Sharon's case, she could have retrieved her list from her purse and reviewed it to assist in her goal not to binge.

Acceptance skills within distress tolerance include radical acceptance, turning the mind and learning the distinction between willingness and willfulness. Radical acceptance is often an especially important skill for those with NSSI and ED as it enables them to cease railing against adversity and being preoccupied with (and stuck on) past negative experiences. Radical acceptance involves the following principles presented in slogan form:

- Freedom from suffering requires acceptance from deep within.
- Letting go of fighting reality is a path to reduced distress.
- Acceptance is the only way out of hell.
- Pain creates long-term suffering when you refuse to accept and let go.
- Tolerating the moment is accepting as it is rather than trying to change the moment.

Such slogans are designed to enhance motivation and sustain hope. However, radical acceptance does not mean learning to "agree with" or "excuse" past abuse or trauma. There is no submission in radical acceptance. Rather DBT states, "A lot of your problems may not be your fault, but you have to solve them anyway" (Linehan, 1993a).

Sharon found using the distract skill helpful. She explored new hobbies outside the home that provided structure and increased her contact with fellow adults. She found a gym with a day care center and began work with a personal trainer. Walking to the park with her children was relaxing and she practiced playing with them mindfully rather than sitting and watching. Sharon also carried in her wallet lists of pros and cons regarding cutting or binge eating. She reviewed her list of "cons" when urges arose.

Sharon reported that the self-soothe skill was the most challenging as it was difficult for her to feel comfortable with her body. This discomfort was trauma derived. As a corrective response, she and her therapist negotiated that she practice self-soothe daily. With enough repetition, she came to look forward to painting her nails, brushing her hair, getting a haircut, or bathing.

8.5.3 Emotion Regulation

The emotion regulation module teaches clients to identify, name, reduce, and accept intense negative emotions. An educational component provides a definition of emotions, explains how they are experienced in the body, teaches how to differentiate emotions, and practices how to step back and observe and describe emotions. Clients are taught to reduce vulnerability to negative emotions via good nutrition, regular sleep habits, and avoiding mind-altering substances. This module also fosters experiencing positive events and emotions as an antidote to pervasive emotion dysregulation. The skill of "opposite action" involves behaving counter to what an emotion is signaling. Thus, a person who experiences avoidant anxiety regarding an activity (such as applying for a job or going to a therapy appointment) deliberately forces himself and herself to engage in it with a calm confidence. Or a person experiencing anger (and a desire to attack) deliberately behaves in a civil, considerate manner. These emotion regulation skills help individuals feel more in control of their affective lives: they learn to step off the roller coaster of emotional distress onto the firm ground of modulated affective experience.

In returning to Sharon, she found "opposite action" to be an especially helpful skill. She employed it to push herself to become active when depressed about weight or isolation. With repeated practice of this skill, she reported feeling more productive and energetic. She also used opposite action to counter feelings of loneliness by reaching out to other mothers at the gym and connecting using social media. Building on these activities, she surprised herself by reconnecting with old friends from high school.

8.5.4 Interpersonal Effectiveness

The goals of this module are to learn how to initiate, manage, and maintain relationships with others, and retain a sense of self and self-respect within those relationships. This module is the generally the last of the four taught in standard DBT. It is not intended to be a comprehensive social skills training package, but rather a targeted set of skills especially relevant for people with pervasive emotion dysregulation. It certainly is a good match for most individuals with NSSI and ED, who may be prone to stormy and/or inconsistent relationships. Recovering from NSSI in combination with ED requires a lot of social support. Therefore, interpersonal effectiveness skills can be especially important in helping maintain relationships during the taxing process of dual recovery.

The three main skills in the interpersonal effectiveness module bear the acronyms of DEARMAN, GIVE, and FAST. Each capital letter in the acronym refers to a specific skill. While it is beyond the scope of this chapter to review all these skills, the major components are important to mention. DEARMAN provides techniques for meeting one's needs in relationships, asking for help, and saying no to unwanted requests. The GIVE skills emphasize four ways to maintain relationships. For this acronym, G stands for be "Gentle," I for act "Interested,"

DBT Skills Card		***Check* the days you practiced**							**Name: Sharon** **Date: (month 7 in treatment)**
Module	**Skill**	**M**	**T**	**W**	**T**	**F**	**S**	**S**	**Comments about Skill Usage/Practice:** (write a note to remind yourself how you practiced the skill)
Core Mindfulness	Mindful Breathing	x	x	x		x			Practiced breathing in morning during kids' morning nap to deal with urges to cut
	Wise Mind			x			x		Used wise mind before reacting to husband to avoid argument
	Observe & Describe		x						Used when in park with urges to binge (saw ice cream truck), focused on new flowers
	Participate		x						Chased kids around park (couldn't believe how long I could do this for!...15 min straight)
	One-mindfully								
	Non-judgmentally			x			x		Tried to be non-judgmental about the scars on my legs
	Effectively								
	Mindful eating	x	x	x	x	x	x	x	Each formal meal (B,L,D) eat at dining room table. Snacks are harder— on the go.
	Urge Surfing		x				x		Went out to eat with family, urge surfed to get through desire for fish & chips. Enjoyed grilled fish and salad instead and ate only 1 French fry from husband's plate!
	Alternate Rebellion								I addressed my frustration with my husband rather than cutting to "show him"
Distress Tolerance	Distract (ACCEPTS)	x	x	x		x	x		Find myself using these skills to stay out of kitchen and avoid boredom which leads to bingeing
	Self-Soothe	x	x	x	x	x	x	x	Every day! Painted nails, put on make-up even though wasn't going anywhere, treated self to a pedicure at a spa
	IMPROVE		x					x	Encouraged myself to stay strong and not buy ice cream. Even distracted my kids from it.
	PROS & CONS								
	TIP								
	Half-smile								
	Radical Acceptance						x		Certain details of my past
	Turning the mind						x		Had to use while looking at menu to make healthy choice
	Willingness (vs. willfulness)								
Emotion Regulation	Observe Describe Emotions								
	Accumulate Positive activity								
	Build MASTERY					x			Working hard on some gym exercises and getting better at them.
	PLEASE	x	x	x	x	x	x	x	I'm getting quite good at doing this daily tool. I'm proud of the meals I ate and exercise I did.
	Opposite Action			x		x			Used skill to push myself to go to the gym.
Interpersonal Effectiveness	Balance priorities with other's demands		x		x		x		Had to juggle my needs to attend to kids' appointments and husbands late work night. Felt satisfied with outcome
	Balance wants with needs								
	DEARMAN			x					Used skill to negotiate with husband scheduling issues
	GIVE						x		Attentively listened to husband talk about work. Could tell he was happy to be attended to.
	FAST				x				Stuck to my guns with my husband so we could both get our needs met versus me giving in to him like in the past.

Fig. 8.2 Skills card

V for "Validate," and E for using an "Easy" manner. These strategies are designed to assist people prone to explosive, conflictual interactions or sullen withdrawals. The FAST skills teach individuals how to maintain self-respect and remain true to one's values in relation to others. The acronym refers to: be Fair, don't over-Apologize, Stick to your values, and be Truthful.

In Sharon's case, she found the FAST skills to be most beneficial. She emphasized the S skill (i.e., Stick to your values). Sharon was absolutely committed to presenting as a good role model for her children. She was especially dedicated to this principle because positive mentoring was so absent in her childhood. She

decided that cutting herself and binge eating—both of which hurt her body—were not effective modeling for her beloved offspring (even if they weren't specifically aware of the behavior). She said, "I think my kids pick up on my self-harm in subtle ways." To counteract the NSSI and ED, she made a list of her values and carried it in her purse with her other skills prompts. Even when her judgments and feelings about herself became pessimistic and negative, she was able to redirect herself as she strove to be an ideal role model. A core value for her became extinguishing NSSI and ED "for the sake of my children."

In concluding this discussion of group skills training, it is important to show how the groups link to individual treatment and the use of diary cards. Many diary cards have a list of the DBT skills on the reverse side (see Fig. 8.2 for an example). This is commonly referred to as the "skills card." This card provides a concise list of all the skills covered in DBT and facilitates tracking (with related comments). Skills taught in group are monitored as to use in the real world both in the individual therapy and group sessions via the use of the skills card.

As shown in Fig. 8.2, Sharon found that completing her skills card kept her focused in treatment. The tracking was also useful when she experienced urges to self-injure or binge eat; it helped interrupt automatic responses. Sharon also enjoyed her therapist praising her skills practice in therapy; she was an individual who had received very little validation from women. Sharon and her therapist also identified which techniques were most helpful by reviewing the skills cards across sessions. They collaboratively created a "cheat sheet" of her favorite skills for easy reference when urges spiked. Figure 8.2 demonstrates Sharon's extensive use of skills during a single week, after she had completed a full round of skills training groups. That is to say, she had already been trained in the full roster of DBT skills.

8.6 Coaching

Coaching is included as part of standard DBT because it is common for clients to have trouble applying skills in their daily lives. Coaching typically involves phone contact and is conducted by the individual therapist. The protocol is that the client calls the therapist prior to engaging in any problematic behaviors. Coaching calls are unscheduled, brief, and problem specific. They are in-the-moment interventions, not phone therapy. Such calls help clients strategize which skills to use and how to apply them in the natural environment. Coaching also allows clients to have contact with their treaters without having to escalate to crisis level behavior.

Sharon utilized coaching on several occasions. For Sharon, long days of isolation at home were difficult. After a few upsetting relapses of NSSI and binge eating, she agreed to utilize coaching calls. One day when her children were ill, she experienced increasing urges to binge eat to bring temporary comfort. As is common with clients who have multiple target behaviors, she also considered cutting to help avoid binge eating. Motivated to avoid relapse, she called her

therapist. The clinician briefly validated and then directed her—while they were on the phone together—to review her pros and cons lists for binge eating and cutting. Through this process, Sharon identified several "distract" skills she could use. These included finishing a scrapbook, connecting with friends via social media, and mindfully reorganizing her bedroom closet. In addition, her therapist reminded her to "surf the urges" and engage in some breathing exercises. Sharon agreed to call her therapist back if urges worsened. She was able not to relapse.

Although initially hesitant to utilize coaching in the treatment, Sharon found these calls especially helpful when emotions were high and self-deprecating thoughts were persistent. Coaching calls naturally tapered as she reached the end of treatment.

8.7 DBT Consultation Team

As the above description of DBT individual therapy, group skills training, and coaching has indicated, DBT is an exceptionally complicated treatment. The weekly consultation team is designed to assist DBT practitioners in learning the complexities of the treatment while delivering it according to protocol (Linehan, 1993a). A standard approach in consultation team is to review treatment strategies and listen to recordings of sessions (with consent having been obtained). Such peer consultation provides direct, validating, nonjudgmental feedback and guidance. Linehan's standard outpatient model (1993a) typically includes both the individual therapists and group skills trainers. However, anyone involved in the treatment can be part of the consultation team, including milieu counselors in a group home or inpatient unit, nutritionists, nurses, and physicians.

A second major agenda for DBT consultation teams is addressing caregiver burnout. Working with self-destructive clients can be confusing, frightening, and draining. Professionals need the opportunity to debrief their own emotional distress so that they can maintain a therapeutic frame. This support also helps professionals maintain adherence when they might be tempted to drift from protocol. Consultation team is best conceived as a "team of therapists treating a team of clients" (Linehan, 1993a). The team helps practitioners not feel alone in treating challenging individuals.

During Sharon's treatment, she alternated early on between NSSI and binge eating. The consultation team "treating Sharon" included her individual therapist and group skills trainer and other experienced DBT clinicians. The team offered her two treaters opportunity to collectively strategize on a weekly basis about how to help with her interwoven self-harm behaviors. Sharon appreciated her therapist bringing new ideas from the team to help address her DBT targets. Even though she never met the team members, Sharon perceived them to be an extra source of support, an anonymous group of cheerleaders.

8.8 Concluding Comment on the Case Example

Sharon completed standard DBT in one year. She engaged in weekly individual therapy and two rounds of skills training, where she learned each skill twice. The purpose of this repetition was to increase consolidation of skills. She was a highly motivated client who had strong attendance in the treatment modalities. She used coaching with her therapist occasionally and strategically. By the end of treatment, Sharon had ceased both binge eating and cutting. She had lost 42 of her 50 lb weight gain and was feeling much better about her body image. She attributed her success primarily to her mindfulness, distress tolerance, and "sticking to her values" skills and the restorative relationship with her consistently validating therapist. Sharon was also able to do some productive work about her trauma at the hands of her brother, which provided her profound relief.

Nine months after the treatment ended, Sharon called the therapist to refer a friend for treatment. In the course of that conversation, she confirmed that she was still free of cutting and binge eating. She reported, "I rarely think about doing those things anymore."

8.9 A Note on More Challenging Clients

The case description in this chapter involved an individual who was moderately challenged, worked hard in treatment, and responded with extinction of her problem behaviors. It should be noted that DBT has been employed successfully with far more challenging individuals than Sharon. For example, the senior author of this chapter described an application of DBT in a residential treatment program for severely disturbed adolescents (Walsh et al., 2012). The program serves youth who present with recurrent suicidality, high rates of NSSI, serious eating disorders, substance abuse, and risk-taking behaviors. Their complex problems have led to high rates of psychiatric hospitalizations and removal from their family homes.

As Walsh et al. (2012) reported in their outcome study of the adolescent program ($N = 66$), DBT has been shown to be effective in largely extinguishing suicide attempts and NSSI in the clients served (6 months post-discharge). They also found a "dosage effect" in that clients who received two rounds of DBT did better than those who received less than one. Those who received more treatment had significantly lower rates of subsequent psychiatric hospitalizations and were significantly more likely to return home to family of origin.

Conclusion

A distinct advantage of DBT is that it places great emphasis on motivational strategies to assist clients in entering into treatment. In addition, it has been shown to be successful in keeping them in treatment once involved (i.e., DBT has been shown to have lower rates of dropout than treatment as usual; Linehan, 1993a; Miller et al., 2007). Such ability to engage and retain is especially important with seriously challenged individuals who may have experienced multiple previous

treatment failures. The concluding point to be emphasized is that DBT has been used successfully with persons with very severe dysfunction and should be seriously considered as a treatment option when such problems are encountered clinically. This would appear to be especially true for individuals who present with the double trouble of non-suicidal self-injury and eating disorders.

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