Dialectical Behaviour Therapy for the Treatment of Eating Disorders

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There have been many advances with respect to DBT and its application to eating disorders since I first wrote this article. This updated version includes important developments and information about why we use DBT, how we use it, and which type of DBT to apply.

What is Dialectical Behaviour Therapy?

Dialectical Behaviour Therapy (DBT) was developed by Marsha Linehan in the 1990s to help people struggling with recurrent suicidal and self-harming behaviours[1]. The treatment was born out of her frustration with the lack of treatment options for this patient group, the poor reputation they had in psychiatric/medical environments, and out of a desire to create a novel care pathway. What Linehan created changed the face of psychological care for a patient population once considered treatment resistant. At the heart of DBT is a dialectical worldview which seeks to find a synthesis between opposing views, rather than find the "right" answer. Sophisticated and multimodal (i.e., includes individual therapy, skills training, phone coaching, and consultation to therapists), DBT blends cognitive behavioural approaches with meditative practices and acceptance-based strategies to create a truly unique therapy modality.

The success of DBT in targeting suicidal and self-injurious behaviours, reducing the need for high levels of psychiatric care, and improving quality of life was noted around the world. Over the past 30+ years, and thanks to international groups of researchers, DBT has evolved into a robust treatment option for anyone struggling with other impulsive and problematic behaviours for whom emotion dysregulation plays a central role. For a review of current research on DBT, please see: Core Evidence & Research - Behavioral Tech Institute (behavioraltech.org)

What is Emotion Dysregulation?

Our ability to experience feelings, tolerate painful emotions, and communicate our needs plays a vital role in our mental health and overall wellbeing. The term "emotion dysregulation" has been used when people have long-standing difficulties coping with unpleasant feelings or when emotions are experienced as so overwhelming that they lead to behaviours (e.g., self-injury, restricting). For some people, emotions become so unbearable that they cope by trying to avoid or suppress feelings (e.g., they may be hard to read). Other people find that their emotions lead to impulsive or self-destructive behaviours (e.g., shame leading to binge eating or anxiety driving food restriction).

How Does Someone Develop Emotion Dysregulation?

In DBT, the Biosocial Theory has been developed and researched to explain what causes and maintains emotion regulation difficulties.

Researchers believe that some individuals are naturally (or biologically) more sensitive to their emotions from birth (e.g., they may be especially sensitive to emotional cues, experience more intense emotions, or take longer to "return to baseline" once activated). But biology alone cannot explain the whole picture. What Linehan learned was that people who were more emotionally sensitive (biological super-feelers) were also more likely to have significant histories of being invalidated. Invalidating environments communicate that a person's feelings, needs, thoughts, or behaviours are incorrect, unacceptable, bad, or otherwise inappropriate. Invalidation can happen intentionally or unintentionally and often happens when one person or system doesn't understand the other. Such environments cause a person to doubt their internal feelings and "gut" reactions and question their sense of self in relation to the rest of the world.

As part of MED-DBT (see below), the Biosocial Theory has now been adapted to account for eating disorders (EDs) in that it includes the neurometabolic underpinnings that drive and maintain EDs and the pervasive invalidation that people with EDs experience (e.g., diet culture).

Why DBT for Eating Disorders?

1. DBT is Based on an Emotion Regulation Model

One of the features that makes DBT unique is its focus on understanding and working with emotions. Targeting emotions in the treatment of EDs was not a central part of standard ED treatments (e.g., CBT, FBT). However, research has shown that focusing on emotion regulation is a necessary part of treatment and recovery. For example:

- Many individuals with an ED report difficulty describing, tolerating, and expressing emotions. For many, emotions are experienced as threatening, confusing and completely overwhelming. Other people report feeling numb, empty, and unable to connect with emotions[4,5].

- Clients with EDs often report that they do not have the skills to cope with their emotions in healthy, adaptive ways during treatment or post intensive treatment[6,7].

- Without adequate emotion regulation skills, ED symptoms can become a way of regulating overwhelming and uncomfortable feelings and body states (e.g., gastrointestinal distress), at least temporarily. Many people have reported that their symptoms help them tolerate and control intense and painful emotions. Binge eating, purging, and fasting have been described as coping strategies, "physical escapes", "ways of withdrawing" or as a "temporary relief" from emotional pain and discomfort[8, 9].

- Negative emotions are one of the most common triggers for ED symptoms. Studies which have tracked emotional states before and after episodes of binge eating have shown that depression, anger, guilt, loneliness and self-blame are significantly higher on days in which people engage in symptoms[10].

- If left untreated, emotion dysregulation may increase a person's vulnerability to relapse following treatment. Several studies have found that people are more likely to maintain their recovery from an ED when they feel that they can better identify, accept and tolerate emotions[6,7].

2. DBT Focuses on Motivation as a Central Treatment Target

EDs are known for their ego-syntonic nature (e.g., having qualities that a person doesn't want to get rid of) and can be characterized by anosognosia, a neurological condition in which a person is not aware of the seriousness of their illness). Motivation to change waxes and wanes and DBT uses a set of strategies to work with this throughout treatment.

3. The Driver in DBT is to Build a Life Worth Living

For many clients, symptom focused treatments have not been sufficient and, for some, have been experienced as traumatic and coercive. DBT balances the need for safety and medical stability with truly chasing a life worth recovering into. For many, the goal of stopping purging because they have an ED is not enough. As my colleague Lucene Wisniewki teaches, our clients need the bigger "*WHY*" (e.g., "I want to travel this summer and purging leads to medical instability which will stop me from going so that is WHY I need to target this behaviour").

4. DBT Helps People Learn and Hone Skills to Build That Life Worth Living!

It is difficult, if not impossible, to change over-learned behaviours that have served to help a person cope without learning new ways of being in the world (and in one's body). Our clients and their families often tell us that they need help tolerating anxiety and anger around meals and beyond or navigating suicidal and self-injurious thoughts and behaviours while trying to decrease ED symptoms. In DBT, clients receive in-depth training across 4 domains:

Mindfulness skills: designed to teach people how to focus attention on the present moment without judgment. Very often, people with EDs have difficulty staying in the "here and now". Connecting with emotions, with the body, and with food is very triggering for someone with an ED. Mindfulness skills help individuals gain insight into their patterns and behaviours and allows them to observe thoughts and feelings without judging or acting on them.

Interpersonal Effectiveness: Individuals with EDs often report that they have difficulty asserting their needs, saying no to others, and putting their goals and desires before those of others. Often this comes from a place of fear (e.g., fearful of being rejected/disliked by others) or shame (e.g. the belief that one's needs are not important). Maintaining relationships and negotiating needs with others is central to our wellbeing.

Interpersonal effectiveness skills teach people how to effectively communicate with others and how to increase the likelihood of getting their needs met.

Distress Tolerance: These skills are designed to help clients get through a crisis without making matters worse. In this module, clients learn a range of strategies for coping with stress and crises in a way that minimizes harm and are in line with the life values of our clients. These are often the first skills people learn to use to interrupt symptoms and gain confidence that there is a different way of navigating difficult situations.

Emotion Regulation: Unlike distress tolerance skills, emotion regulation skills are the daily things we teach clients to do to improve quality of life and reduce vulnerability to "emotion mind". People will learn how to observe and describe their emotional world without fear, judgment, or self-hatred. These skills emphasize the adaptive nature of all emotions, teaches clients how to problem-solve, change their emotions when needed, and challenge myths about emotions.

What Does DBT for Eating Disorders *LOOK LIKE*?

Over the past 20 years, researchers have been studying when and how to use DBT for those with EDs. There are different ways that DBT has been adapted for EDs. It is important to know that they are not all the same and they have important differences. Each is designed for different ED presentations or, in DBT, "stages" of illness.

Debra Safer and colleagues developed the Stanford Model[11] or the DBT-BN/DBT-BED model. This evidence-based approach is designed for people with bulimia or binge eating disorder who DO NOT have major co-occurring conditions that need attention. In DBT, these models are suited for people in "Stage 3" presentations where the individual is more stable and not in crisis. This approach is also skill-based only and offered individually or in a group setting. It is NOT comprehensive DBT and is not designed for people struggling with suicide/self-injury or other co-occurring difficulties.

Radically Open DBT, in my opinion and experience, would be another potential Stage 3 approach. It is NOT designed for people with EDs who are medically unstable or those who need help with eating and weight stability. It is not designed to help with the dysregulation one experiences when facing food and body image issues. It is also not a trauma treatment which is what predominately defines "Stage 2" work in DBT.

MED-DBT[12] is a treatment for people with an ED with "Stage 1" difficulties, meaning they are caught in emotional and behavioural chaos and suffering that has to be managed before doing deeper emotional or trauma work. For us that typically means people need help staying alive both in terms of the ED and with respect to managing suicide and self- injury and need a much more dialectical approach.

MED-DBT consists of four major components:

1. Individual Psychotherapy

2. Skills Training Group Therapy
3. Skills Coaching by Telephone
4. Consultation Team for Therapists

The following are several suggested readings for more information:

Anderson, L. K, Murray, S. B., Ramirez, A. L., Rockwell, R., Le Grange, D., & Kaye, W. H. (2015). The integration of family-based treatment and dialectical behavior therapy for adolescent bulimia nervosa: Philosophical and practical considerations. *Eating Disorders, 23*(4), 325-35. doi: 10.1080/10640266.2015.1042319

Ben-Porath, D., Duthu, F., Luo, T., Gonidakis, F., Compte, E.J., & Wisniewski, L. (2020). Dialectical behavioral therapy: An update and review of the existing treatment models adapted for adults with eating disorders. *Eating Disorders, 28*(2), 101-121. doi: 10.1080/10640266.2020.1723371

Federici, A., Wisniewski, L., & Ben-Porath, D. (2012). Description of an intensive dialectical behavior therapy program for multidiagnostic clients with eating disorders. *Journal of Counseling and Development, Special issue on prevention and treatment of eating disorders*, 90, 330-338.

Wisniewski, L., & Safer, D.L. (2021). DBT and Eating Disorders, In Linda A. Dimeff, Shireen L. Rizvi, Kelly Koerner, Elissa M. Ball, Brad Beach (eds.), *Dialectical Behavior Therapy in Clinical Practice: Applications Across Disorders and Settings (2nd ed)*, Guilford Press.

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functioning? *European Child & Adolescent Psychiatry*. 11, 38-42.

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[9] Heatherton, T. F., & Baumeister, R. F. (1991). Binge eating as escape from self awareness. *Psychological Bulletin*, 110, 86-108.

[10] Stein, K. F., & Corte, C. M. (2003). Ecologic momentary assessment of eating disordered behaviours. *International Journal of Eating Disorders*, 34, 349-360.

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[12] Federici, A., Wisniewski, L., & Ben-Porath, D. (2012). Description of an intensive dialectical behaviour therapy program for multidiagnostic clients with eating disorders. *Journal of Counseling and Development, Special issue on prevention and treatment of eating disorders*, 90, 330-338.