Traditional and Radically Open DBT for Eating Disorders: TIBs and the Treatment Hierarchy

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Introduction

In the final segment of this interview series on DBT and bulimia, Dr. Michael Maslar discusses the importance of between sessions support as a form of context-dependent learning.

He also distinguishes between traditional standard DBT (which was designed to treat disorders of underregulation) vs radically open DBT (which was designed to treat disorders of overregulation). Since eating disordered behaviors can potentially involve both underregulation and overregulation, both approaches can be effective.

Finally, Michael discusses the treatment hierarchy for treating symptoms of bulimia. In addition to distinguishing between therapy-interfering behaviors vs relationship ruptures, he outlines a specific sequence of treatment priorities.
Do you find the DBT concept of between-sessions support to be helpful with clients with eating disorders? Do you encounter the same sort of crises that you would have with the population with borderline personality disorder?

Certainly. In DBT, there’s a target hierarchy for each one of the modalities of treatment. For phone coaching, you have a target hierarchy of addressing suicidal and life-threatening behaviors first and foremost, and then helping people to use skills that they are learning in therapy. Finally, we address a sense of distance or alienation from the therapist.

Those categories of behaviors can be addressed with eating disorders. Some people with eating disorders self-injure and may be suicidal. So certainly, it is useful for the therapist to be available for that.

In particular, with eating disorders, the second level of the hierarchy, addressing skills use, is helping coach people in using emotion regulation skills. This helps manage emotion dysregulation so that the person doesn’t take that step of bingeing and then purging.

In any therapy, one big obstacle that people face when they’re trying to make changes in their lives is taking what they’re learning in the therapy session and applying it in everyday life.

DBT and therapies like DBT that offer this component are essential for helping people learn how to take what they’re...
learning in therapy and practicing it, using emotion regulation rather than bingeing. This is because our learning is highly context-dependent.

There’s research that shows that if you study in the room where you’re going to be taking an exam, you tend to do better than if you studied somewhere else. Even just the physical surroundings cue up behaviors. Sitting with your therapist in the therapy environment is very different than day-to-day life.

Phone coaching helps bridge the gap between what’s happening in the therapy room or in the skills training group with day-to-day life.

Kirby
In your work with clients with eating disorders, are you utilizing mostly standard DBT, radically open DBT, or a combination of both?

Michael
It depends on the eating disordered behavior. In binge-purge types of behaviors, like bulimia nervosa, standard DBT is what is indicated.

Radically open DBT, on the other hand, is the first treatment that we have that shows efficacy with adult anorexia nervosa. The therapist can make those distinctions based on the type of problem that a person has or their diagnosis.

Kirby
What are some of the key distinctions between standard DBT vs radically open DBT?

Michael
There are minor modifications to standard DBT that have been developed for eating disorders, like bulimia nervosa, antisocial personality disorder, dissociative disorders, or substance-related disorders.

Radically open DBT is a major adaptation of DBT that is dissimilar in lots of ways. It’s still a behavioral treatment and integrates mindfulness skills into its work. The difference is that it addresses the whole collection of behaviors that are on the opposite end of a spectrum or dialectic from all the other
behaviors that are addressed with standard DBT, which can be thought of as undercontrolled behaviors.

This is where we make the assumption that emotion dysregulation drives a lot of the problem behaviors because a person has difficulty acting in regulated ways. That's undercontrol and standard DBT.

Radically open DBT addresses people who have too much of a good thing. They exert too much control over themselves. They can't connect with other people. They have difficulty being flexible and being able to address problems effectively in the world because they operate by rules which don't always fit.

It's not about emotion dysregulation. It's about problems with being open to new learning, being flexible, and being isolated. This is opposed to problems with standard DBT that are about being out of control in some ways.

That's the core issue with eating disorders, the sense of when binging that one's behavior is out of one's control. So radically open DBT is very different. It has almost completely different skills than the ones we teach in standard DBT. The treatment hierarchy in individual therapy is almost completely different than in standard DBT.

There are major differences also in the way that the therapist tends to interact in radically open DBT vs standard DBT. Those 2 treatments have diverged quite a bit, but they still share the same basic behavioral and mindfulness principles.
Underregulation and Overregulation in Eating Disorders

Kirby Would it be fair to say that eating disorders can be a matter of underregulation as well as overregulation?

Michael Depending on the specific function of the behaviors, yes. The form is different. The problems of people who mainly restrict are associated with overcontrol.

That’s the nature of restricting and compensatory behaviors. I’m exerting control over my body. People who are on the opposite end may experience emotion dysregulation and they may go back and forth between losing control and then getting control again, whereas the person who is overcontrolled tends to be overcontrolled and in control too much of the time, and in ways that interfere with their goals.
Radically Open DBT

Kirby: Can standard DBT and radically open DBT be useful for this population at different times?

Michael: Depending on whether the basic underlying problem is one of emotion regulation, I will primarily be doing standard DBT. I may bring in some of the skills from radically open DBT, but I’m fundamentally doing standard DBT.

It’s the same if I go in the other direction. If I’m working with somebody with anorexia nervosa, we’re primarily doing radically open DBT, but I may pull in skills from standard DBT because they can help anybody.

I have a basic therapeutic approach. I try to be as adherent as possible and then maybe bring in skills from the other treatment when needed.

Kirby: What is the second priority in radically open DBT?

Michael: In standard DBT, we deal with a lot of therapy-interfering behaviors, we address them as such because that’s important. We work with therapy-interfering behaviors because that makes the whole therapy work more effectively.

In radically open DBT, we tend to view behaviors that might interfere with the therapy as signs of relationship rupture. In that second tier of the hierarchy, we’re looking for relationship ruptures. Then we bring in a rupture repair protocol and begin to work on the relationship.
This is because one of the fundamental difficulties with overcontrol is that the person has difficulty connecting with another person.

That is part of the therapy relationship. You’ll get people who have problems with overcontrol and they’ll look very engaged in the therapy and they are. They are very compliant because that’s what they’re supposed to do, but not because they have a connection with a therapist.

It usually takes several alliance ruptures to happen so that that person has the visceral experience of having a relationship rupture with another person that gets addressed effectively and the relationship is repaired.

People with overcontrol often are isolated. One of the reasons is because they’ve been unable to effectively address problems connecting with other people in their lives. They don’t necessarily have the connectedness experience.

Ultimately, in radically open DBT, it’s having that deep connection with the therapist that’s important. It gives the person the experience of being able to connect with other people. There’s that difference in the hierarchy. We certainly have behaviors in radically open DBT that interfere with the therapy but we tend to assess them as connected to alliance ruptures.
Eating Disorders and Treatment-Interfering Behaviors

Kirby: When you’re working with eating disorders, what do you find to be more problematic, treatment-interfering behaviors or ruptures in the therapeutic alliance?

Michael: It depends on whether the person is undercontrolled or overcontrolled.

Many people who are undercontrolled also have a very basic kind of relationship hunger. They want to connect and to be able to depend on you as the therapist. They want to connect with other people in their lives. We’ll work on therapy-interfering behaviors as such.

People with overcontrol are very threatened by connection because they haven’t learned how to do it well. Rather than addressing the behavior that interferes with therapy simply for what it is, patients with eating disorders will try to be compliant. But this doesn’t address what might be connected functionally to those problem behaviors as the therapy relationship.

“Are you really connecting? Are you letting me know that I understand you? Are you helping me to correct that when I don’t understand you?” Those are really basic fundamental skills related to connecting with another person that will make the therapy more effective.
That second tier of the hierarchy, in both standard DBT and radically open DBT, addresses making the therapy more effective, coming at it from different directions.
Teaching DBT Skills

Kirby
What are some of the most difficult DBT skills to teach clients with eating disorders?

Michael
Mindfulness, mindfulness of behaviors related to eating, and behaviors related to one’s body. When I say behaviors in DBT, we have a radical behavior space that we work from. In that space, everything that a person does is a behavior.

What I do outwardly, my overt behavior, is also what I do inwardly. My thoughts are behaviors. My emotions are behaviors. Even my basic physiological activity, like respiratory rate or heart rate, are behaviors as well.

Practicing any of the skills that we learn in DBT and mindfulness, in particular, of eating disorder-related behaviors can be difficult. When practicing self-soothe skills, be careful about which senses are being used and how they’re being used for self-soothing.

With emotion regulation, it is difficult to be able to help to get the idea and the practice of using emotional regulation rather than the problem behavior. These are mindfulness skills, distress tolerance skills, and emotion regulation skills.

There are challenges in each of those areas and others depending on the person.
Minor Adaptations That Can Be Made to DBT to Treat Bulimia Nervosa

Kirby

What are the minor adaptations that it's possible to make to standard DBT, specifically with bulimia nervosa in mind?

Michael

As part of the hierarchy of treating behaviors in individual work with eating disorders, the most important level if someone has suicidal behavior or self-injury, is addressing that first and foremost. The second tier is stopping therapy-interfering behavior. That's the way it is for any adaptation of DBT.

Once we get into the third level of the hierarchy with eating disorders, the following sets of behaviors are important in this order, and this helps to organize and focus the therapy. The next behavior to address is stopping bingeing. Then, eliminating mindless eating or practicing mindful eating. We aim to decrease cravings, urges, and preoccupations with food using skills to do that.

Decrease giving in to urges. Help people understand that it’s a choice that they make to give in. Decrease apparently irrelevant behaviors. “I just brought these leftovers from the office because I think my son would like them but then I binge on it.” Buying large quantities of binge foods for guests if people show up. “Now, I have this binge food that’s around.” We aim to decrease apparently irrelevant behaviors that just make it harder for a person to be able to stop bingeing and then purging.

Then increase the use of skills. We talk about all of these sets of behaviors and working on them in that order as the pathway
in DBT that’s adapted for eating disorders. We call that the pathway to mindful eating overall.

After suicide behaviors and treatment-interfering behaviors, Marsha Linehan addresses anything that interferes with the quality of life. What you’ve done is expanded that and made that much more concrete.
Integrating Other Models to DBT

Kirby Have you found it useful to integrate other models outside of DBT world altogether when you’re working with clients with eating disorders?

Michael Virtually any behavioral treatment that’s in existence, and I include cognitive-behavioral treatments because they share the same base as DBT and can be integrated into DBT. There’s a way that DBT is the shell that you can insert all kinds of other protocols, like CBT for OCD, CBT for phobias, exposure treatment for trauma, and cognitive processing therapy for trauma.

These are all therapies that can be used within standard DBT. I often do bring them in, depending on what the person needs, of course.

Kirby What are your favorite DBT skills that you use in your own life?

Michael The way that most training in DBT proceeds is that the clinician who’s learning DBT has to learn the skills and has to learn their use through practicing in their own lives. This makes it easier to teach the skills but it’s also crucial to have an effective therapy practice, especially if you’re working with a lot of clients who have emotion dysregulation problems.

It can be stressful. It’s important that the therapists are skillful themselves for the therapy process, not to mention that it can make your life a whole lot better outside of the therapy room. That’s often the report that I get from people that I train, and what we hope for is you’re using skills in everyday life.
almost always say, “This has made my personal life better because I learned these skills.”

Mindfulness skills are very fundamental to me. I practice the skills and do formal practice as often as I can. Certainly, emotion regulation is important. A big one from distress tolerance is practicing radical acceptance. That probably is the skill that I use and work on the most and the one that has helped me live a happy and fulfilling life.
Main Points

1. Learning tends to be context-dependent. Even though the counseling office is a safe environment for learning new skills, it’s often difficult for clients to apply those skills in real-life situations outside of the counseling office.

2. DBT therapists need to provide between-session support so that clients can generalize skills learned in session to their own real-world settings.

3. Standard, traditional DBT was developed to treat disorders characterized by symptoms of underregulation, such as borderline personality disorder. Radically open DBT was designed to treat disorders characterized by symptoms of overregulation, such as obsessive-compulsive disorder.

4. Overall, standard DBT is more effective for treating symptoms of bulimia, whereas radically open DBT is more effective for treating symptoms of anorexia. However, since eating disorders can involve forms of both underregulation and overregulation, both approaches can be effective.

5. For clients who tend to be underregulated, it’s important to address treatment-interfering behaviors; otherwise, treatment will be undermined. For clients who tend to be overregulated, treatment compliance will not be an issue, but that does not mean they feel connected to the therapist—in which case, treatment will still be undermined. Therefore, for clients who tend to be overregulated, it’s important to address relationship ruptures instead.
6. When specifically treating symptoms of bulimia, treatment should also focus on the following priorities, in order:

- Eliminate any life-threatening behaviors.
- Decrease treatment interfering behaviors.
- Stop bingeing.
- Eliminate mindless eating and replace it with mindful eating.
- Decrease cravings/preoccupation with food.
- Decrease capitulating to urges.
- Decrease apparently irrelevant decisions.
- Learn other skills to foster an overall healthier life.