CHAPTER 2

Orientation for Therapists

This chapter provides an orientation for therapists before they begin to implement treatment with clients. To provide context, we first describe the impetus behind this adapted DBT treatment's development. This is followed by a brief review of the empirical evidence for standard DBT. We then provide an introduction to this treatment model and assumptions and rationale that underlie this therapy, as well as its goals and targets. The final section of the chapter focuses on the delivery of this treatment, including basic therapist strategies and specifics regarding how sessions are structured.

IMPETUS FOR DEVELOPMENT OF THIS BOOK

The impetus for developing the treatment described in this book originated from years spent by one of us (C. F. T.) treating clients with eating disorders and conducting clinical research in this area. Part of this work included an ongoing search for more effective treatments for eating disorders. As discussed in Chapter 1, a sizable number of individuals with BED and BN do not receive maximum benefit from currently available psychotherapy treatments (e.g., CBT, IPT, BWL).

I reasoned that one potential explanation for this suboptimal treatment response may be a failure of such treatments to directly target the emotional aspects of binge eating. In other words, despite the considerable descriptive and experimental research supporting the relationship between emotional distress and disordered eating, neither CBT, IPT, nor BWL is based on an affect regulation model for binge eating.

In seeking more efficacious treatments for binge eating, I discovered a treatment developed by Marsha Linehan for individuals with borderline personality disorder: DBT. Standard DBT is based on the assumption that borderline personality disorder is best conceptualized as a dysfunction of the emotion regulation system such that many impulsive behaviors (e.g., suicidal behavior and nonsuicidal

self-injury) are maladaptive attempts to regulate painful affects. As I investigated this treatment and received formal training in DBT, I became more convinced that the treatment model, principles, and strategies could be usefully adapted to treating individuals with eating disorders; thus the development and research that underlie this treatment manual.

In developing standard DBT, Linehan synthesized her clinical and research experience with BPD with principles and concepts from Western philosophy (dialectics), CBT, and both Eastern (Zen) and Western contemplative practices. DBT may be thought of as a synthesis of these divergent ideas and the application of this synthesis as a new means of treating emotional difficulties. DBT synthesizes a focus on both change and acceptance in the skills that are taught in the treatment.

Since originally developing standard DBT in the 1980s, Linehan (1993a, 1993b) standardized DBT into two manuals. These manuals, which describe the basics of dialectical philosophy, the therapeutic communication of both acceptance and change, and the core assumptions of DBT, should be read before applying the adapted treatment described in this book. As I worked to adapt DBT to eating disorders, I received extensive consultation from Linehan. With Linehan's permission, I "lifted" a great deal from Linehan's manuals and transplanted it into my original manual—*Emotion Regulation Skills Training Treatment for Binge Eating Disorder* (Telch, 1997a)—which serves as the basis for this book. Although each of the authors of this book has added her own thoughts and made modifications targeting the content of DBT to eating disorders, it is accepted that the adapted treatment presented is more or less an offspring of Linehan's manual. Therefore, Linehan's manuals are not cited each time material from them is used.

BRIEF REVIEW OF EMPIRICAL EVIDENCE FOR STANDARD DBT

Standard DBT is currently the most strongly empirically supported affect regulation treatment for borderline personality disorder (American Psychiatric Association, 2001) and is regarded as the treatment of choice for this disorder (Lieb, Zanarini, Schmahl, Linehan, & Bohus, 2004; Linehan, Comtois, et al., 2002). There are multiple randomized controlled trials of standard DBT to date (Linehan, Armstrong, Suarez, Allmon, & Heard, 1991; Linehan et al., 1999; Turner, 2000; Koons et al., 2001; Linehan, Dimeff, et al., 2002; Verheul et al., 2003; Linehan et al., 2006) and a number of nonrandomized controlled trials (Barley et al., 1993; Bohus et al., 2000; Stanley, Ivanoff, Brodsky, Oppenheim, & Mann, 1998; McCann, Ball, & Ivanoff, 2000; Rathus & Miller, 2002; Bohus, Haaf, & Simms, 2004).

With standard DBT, compared with treatment as usual (Linehan et al., 1991) or the more rigorous comparison of treatment by expert nonbehavioral therapists (Linehan et al., 2006), suicidal clients with borderline personality disorder (1) were significantly less likely to engage in suicidal behavior or nonsuicidal self-injury; (2) reported fewer episodes of suicidal behavior or nonsuicidal self-injury; (3) had less medically severe suicidal behavior or nonsuicidal self-injury; (4) were more likely to remain in treatment; (5) had fewer inpatient psychiatric days; (6) reported less anger; and (7) reported improved global and social adjustment at the end of treat-

ment. All clients improved over time, with reduced symptoms of depression, hopelessness, and suicide ideation (Linehan et al., 1991; Linehan, Heard, & Armstrong, 1993; Linehan, Tutek, Heard, & Armstrong, 1994; Linehan et al., 2006). These findings were maintained at 1-year follow-up (Linehan et al., 2006).

Randomized controlled trials utilizing DBT for the treatment of borderline personality disorder and illicit substance use have also been efficacious (Linehan et al., 1999; Linehan, Dimeff, et al., 2002). Both of these studies demonstrated that participants assigned to DBT had significantly greater reductions in illicit substance use compared with a control treatment (Linehan et al., 1999; Linehan, Dimeff, et al., 2002).

INTRODUCTION TO TREATMENT MODEL, ASSUMPTIONS, AND RATIONALE

Before starting to work with clients using this treatment, therapists need to familiarize themselves with the basic definitions of emotion and emotion regulation as understood in DBT. Briefly, emotions are powerful biologically based reactions that organize our responses to internal and external stimuli. Emotions can be thought of as complex phenomena that affect the total response of an individual. Emotions have many "parts," including, but not limited to, the emotional experience (e.g., fear), the emotional expression (e.g., running), and the physiological activity (e.g., sweating). Although these basic components are shared, individuals will, of course, differ in (1) the intensity or strength of emotions; (2) the experience of positive and negative emotions; (3) emotional lability (i.e., how emotions fluctuate); and (4) the experience of particular emotions (e.g., shame, guilt). According to the DBT model, emotion regulation involves attempts by the individual to influence, change, or control emotions either by preventing an emotion from getting started (e.g., avoiding a feared situation) or by attempting to change the emotion once it has gotten under way (e.g., escaping a feared situation). Adaptive emotion regulation requires the ability to label, to monitor, and to modify emotional reactions, including the ability to accept and tolerate emotional experiences when emotions cannot, in the short run, be changed.

The theoretical model on which this treatment is based proposes that the core problem for individuals with BED and BN is emotion regulation dysfunction. This dysfunction is a result of both emotion vulnerability and inadequate skills for adaptive emotion regulation. That is, this model posits that a central and primary problem for these individuals involves deficits in labeling, monitoring, modifying, and accepting emotions.

Because individuals with BED and BN have underdeveloped emotion regulation skills, they frequently rely on maladaptive means, such as binge eating and/or purging, to control emotions. These behaviors may alter or influence emotions by distracting or suppressing emotional experience and expression, as well as by calming physiological arousal. The temporary relief provided strengthens the binge eating and/or purging as an emotion regulation strategy, and these behaviors become automatic, overlearned responses to emotion dysregulation, crowding out more adaptive strategies. Binge eating and/or purging behaviors are maladaptive because they are harmful to the individual in the long run, exacerbating mal-

adaptive emotion regulation and profoundly interfering with physical, personal, and interpersonal health.

This treatment is also based on the assumption that the emotion regulation dysfunction evident in individuals with BED and BN is in part the result of emotional vulnerability. Emotional vulnerability is conceptualized as high sensitivity to emotional stimuli, intense emotional responding, and a slow return to emotional baseline. Individuals with BN report greater overall negative mood (Bulik et al., 1996; Waller et al., 2003), and individuals with BED (Greeno et al., 2000) report significantly more daily negative mood, as assessed on handheld computers, than those without BED. There is supporting research evidence (Masheb & Grilo, 2006) that individuals with BED and BN have emotion dysregulation across all emotions, including positive emotions such as joy and excitement. That is, binge eating and/or purging may be used to regulate strong feelings of excitement because, without adequate emotion regulation skills, the excitement is experienced as overwhelming and threatening. Finally, it is assumed that strong urges or impulses accompany emotions for individuals with BED and BN, as well as strong bodily reactions (e.g., increased heart rate). Therefore, without the requisite emotion regulation skills, individuals with BED and BN find it nearly impossible to refrain from acting on strong impulses to binge eat and/or purge in the face of emotional distress.

Role of Invalidating Environments

This treatment model assumes that the transaction over time between emotional vulnerability in individuals and the experience of a particular type of environment produces the emotion regulation deficits seen BED and BN. This particular environment is described as invalidating and is characterized by a tendency to respond negatively, inconsistently, and/or inappropriately to the individual's private experiences (e.g., beliefs, thoughts, feelings, and/or sensations). For example, to control the individual's behavior, crying may be met with nonresponsiveness, punishment, and/or criticism. Consequently, any expression of positive affect is not affirmed, validated, or attended to. In such environments, children learn that certain emotions and private experiences are unacceptable and dangerous because they lead to rejection, punishment, and disapproval.

The consequences of an invalidating environment during childhood development can include (1) the inability to label feelings, (2) an inability to trust one's own emotions as valid interpretations of events, (3) an inability to tolerate distress or adaptively regulate emotional arousal or emotional reactions, and (4) invalidation of one's own experience. Self-invalidation teaches one to mistrust one's internal states and to rely on the environment for clues on how to respond. This tendency to look for external validation leads to a failure to develop a sense of self. A core part of eating disorders is a preoccupation with external sources to dictate one's ideal weight and shape.

The rationale for teaching adaptive regulation skills to individuals with BED and BN should now be apparent. In order to stop using binge eating and/or purging to regulate emotions, these individuals need to learn adaptive emotion regulation skills that will replace the maladaptive binge eating. Otherwise, if such individuals stop binge eating and/or purging, another dysfunctional behavior may be sub-

stituted. This treatment also assumes that both acceptance and change skills are essential for adaptive emotion regulation.

Treatment Goals and Targets

The goals of treatment, the goals of skills training, and the targets of treatment are stated by the therapist in the pretreatment and first sessions and are outlined in a handout distributed during the first session (Chapter 3, Appendix 3.2). Refer to this material for further detail. Briefly, the primary goal of treatment is for clients to stop binge eating (and purging) and to stop all other problem eating behaviors listed in the target hierarchy (e.g., mindless eating, urges, cravings, capitulating to binge eating). The goals of treatment are accomplished by teaching the adaptive emotion regulation skills—Mindfulness skills, Emotion Regulation skills, and Distress Tolerance skills. Clients are taught to practice and use these adaptive Emotion Regulation skills to replace their maladaptive eating behaviors.

To accomplish these goals when we train our therapists, we teach them to focus on several key points. For example, we advise them to always "keep your eye on the prize"—that is, to remember that this treatment is aimed at stopping binge eating (and purging).[1] Therapists must be firm in their belief that binge eating is a serious maladaptive and destructive behavior that must stop altogether. Therapists are constantly on the lookout for any behaviors that even slightly resemble binge eating and work to help clients substitute the adaptive behaviors taught in the treatment for the problem eating behaviors.

Keeping your eye on the prize requires therapists constantly to link the client's goals of gaining control over eating behavior, specifically binge eating, with learning the skills. It is the therapists' job to convince clients that learning and practicing the Emotion Regulation skills taught in the treatment is critical to achieving their goals of stopping binge eating and gaining control over other problem behaviors. Additionally, it is imperative that therapists link the learning and practicing of the adaptive skills with an enhanced quality of life. That is, binge eating and problem eating behaviors produce guilt and shame and rob clients of their self-esteem and sense of mastery and competence.

Keeping your eye on the prize also requires therapists to adopt the notion of dialectical abstinence. This is described in the second session (Chapter 3, pp. 65–67). Briefly, the essence of dialectical abstinence is that therapists must, simultaneously, outwardly convey a firm conviction that each client in the program can and will stop binge eating while inwardly being poised and ready to "catch" clients when they fail and binge eat. Therapists must be absolutely certain that binge abstinence can be achieved and that clients can immediately stop binge eating at the start of the program. Therapists convey the attitude that this is essential and that there can be absolutely no middle ground. Clients must stop binge eating *now* in order to gain control over their lives. Of course, it is the therapists' job to help

[1]Although only binge eating is usually referred to throughout the remainder of the text, purging and any other compensatory behaviors (e.g., laxative abuse, fasting, overexercise)—when present—are always assumed to be an additional target.

clients figure out what to do in order to stop binge eating and to replace this behavior with adaptive behaviors, and, in this, therapists are very active in prescribing specific skills for clients to engage in to replace binge eating. Therapists provide the momentum, the conviction, the "jump start" until clients can continue this movement on their own. On the other hand, therapists are simultaneously ready to "pick clients up" when they fail. Therapists help clients learn how to fail well. That is, although therapists convey the conviction that clients can and must stop binge eating, therapists nonjudgmentally accept clients who fall short of this and engage in binge eating. Therapists respond to binge eating by acknowledging that binge abstinence is hard while maintaining the conviction that the client can achieve it. After a client breaks binge abstinence, therapists explain that the task now is to accept the disappointment, learn from the failure, and commit from this moment on to repair the self-harm done by never again binge eating.

Keeping your eye on the prize requires attention to the number-one treatment target listed on the target hierarchy—to stop any behavior that interferes with treatment. Therapists are clear with clients that they believe that binge eating and problem eating behaviors will not stop without treatment. Therefore, because the clients' goals are to stop binge eating and to gain control over their eating and their lives, clients must receive treatment to achieve these goals. If clients are not in treatment, they are less likely to get better. Any behavior that interferes with receiving treatment (e.g., absences, late arrivals) are top priority, and therapists, at the onset of treatment, elicit a commitment from clients to address any treatment-interfering behaviors. Once this is made clear, therapists do not need to refer to this again unless treatment-interfering behavior arises.

Within our research trials, a final requirement of keeping your eye on the prize has been that therapists adhere to the treatment protocol described in this book. For example, at the trials run at Stanford, we emphasized to therapists that teaching the skills prescribed is absolutely nonnegotiable. What is negotiable is how they are taught. That is, the strategies used to present them must be employed flexibly. Therapists must decide, when delivering the treatment, whether or not a particular strategy is appropriate to use given the context of what is taking place in the session. For example, the book may suggest using the devil's advocate strategy to enhance client commitment, but given the context of that particular group, Extending may be more appropriate. The strategies or tools used to teach the skills are negotiable and therefore may be used flexibly.

It is important to point out that clients, particularly those with BED, will likely express concern about whether or not treatment is aimed at losing weight. Therapists must validate that this is an understandable concern, one that is shared by the therapists, who are also concerned about the client's weight to the extent that excess weight reflects maladaptive eating behaviors. However, therapists must make clear that this is not specifically a weight loss program in that diet, nutrition, and meal prescriptions are not a treatment focus. It is assumed that clients who learn and use the adaptive skills for regulating emotions taught in treatment will stop binge eating and gain increased control over their eating in general, and as a result their weight may decrease (also see Chapter 3). Clients are asked to monitor their weight weekly to allow evaluation of any changes in weight that coincide with treatment.

DELIVERING THE TREATMENT: BASIC THERAPIST STRATEGIES

DBT for BED/BN utilizes the same treatment strategies as standard DBT (Linehan, 1993a, 1993b). These include its use of dialectical strategies (e.g., balancing validation and change, modeling dialectical thinking), problem-solving and solution-analysis strategies (e.g., chain analysis), stylistic strategies (e.g., irreverence), commitment strategies (e.g., Evaluating Pros and Cons, Playing Devil's Advocate, Foot in the Door, Door in the Face, Connecting Present Commitments to Prior Commitments, Highlighting Freedom to Choose in the Absence of Alternatives, and Cheerleading), structural strategies, and treatment team consultation strategies (e.g., weekly meetings of therapists).

These treatment strategies are described briefly here and given greater detail at relevant points in subsequent chapters.

Dialectical Strategies

DBT is based on a dialectical worldview that stresses the fundamental interrelatedness or wholeness of reality and connects the immediate to the larger contexts of behavior. From a dialectical worldview, reality is not seen as static but as comprising opposing forces (thesis and antithesis) out of which synthesis can evolve, generating a new set of opposing forces. The individual is stuck in polarities, unable to move beyond the conflict, and the therapist assists the client to resolve the dialectical dilemma or conflict and move to a synthesis. The synthesis is a different way of being, a different perspective that moves beyond the conflict. From this viewpoint, the fundamental dialectical strategy used by therapists is to stay aware of the polarities the client is stuck in and suggest ways out (e.g., use of skills).

The primary dialectical strategy for therapists to focus on when delivering this treatment is the balance between acceptance and change. The essential "attitude" of therapists that pervades this treatment is one of sensitivity to the balance between the need for clients to accept themselves just as they are and the need for them to change. This dialectic is clearly represented by the concept of dialectical abstinence. The guiding principle of dialectics is also reflected in the skills taught, including both Radical Acceptance and Loving You Emotion—in addition to skills for changing emotions. The therapist must both accept and validate the current circumstances of the individual while simultaneously teaching behavioral skills that deliver the message that things must change.

The therapist balances pushing the client toward change in order to have a better life and holding the client with an acceptance of how the client is in the moment. In this context, the therapist must be acutely aware of the client's tendency toward imbalance in either leaning too far toward pushing for change or not changing despite change being needed. It is the job of the therapist to provide the balance. The aim is to help clients become comfortable with change and to accept change as part of reality.

The dialectical attitude toward acceptance and change is conveyed in part by the therapist's balanced application of both validation and problem-solving strategies. The essence of validation is the communication that a response is understandable in the current context. Given the current set of circumstances and the client's

learning history and belief structure, the therapist recognizes and communicates that the client's response makes sense and is valid. Validation is not sugarcoating, whitewashing, or reassuring. For example, if the client claims: "I'm so stupid to have let my boss get to me so that I ended up going home and binge eating after work," validating this client would not mean saying, "You're not stupid." Validating would involve acknowledging the client's experience of feeling stupid, commenting that it is both understandable that the client responded as she or he did and that she or he feels stupid in hindsight. Validating does not include validating the invalid. So in this case the therapist would not want to validate binge eating as an effective response to emotional distress.

In a nutshell, a dialectical treatment approach (1) searches for synthesis and balance to replace the rigid and dichotomous responses characteristic of dysfunctional individuals and (2) enhances clients' comfort with ambiguity and change, which are viewed as inevitable aspects of life.

Of the many dialectical strategies (see also Linehan, 1993a, Ch. 7, pp. 199–220), two others noted here are Extending and Making Lemonade Out of Lemons. In Extending, which is based on aikido, the therapist stays with a client rather than opposing him or her and then takes the client one step further so that the client is thrown off balance and is more open to new direction. The essence of Making Lemonade Out of Lemons is making opportunities out of difficult situations. As Winston Churchill reportedly said, "The pessimist sees the difficulty in every opportunity. The optimist sees the opportunity in every difficulty." It is important to convey that one can learn from mistakes. For example, individuals with BED and BN often feel demoralized and filled with shame after a binge, with a tendency to avoid thinking about the episode. In such an instance, the therapist acknowledges the "lemons" while also utilizing the experience as an opportunity to understand the antecedents to the problem behavior and to identify effective skills to be employed next time. Therapists should look for multiple opportunities to employ this strategy and help clients learn to pick themselves up from "failures" by turning the failures into learning experiences.

Problem-Solving and Solution-Analysis Strategies

Problem-solving strategies involve a two-stage process of, first, accepting that there is a problem and, second, generating alternative adaptive responses. This means that the therapist first helps the client to observe and describe in a nonjudgmental manner the problematic binge-eating and impulsive-behavior patterns. Second, following the nonjudgmental analysis of the problem eating behavior, the therapist helps the client to generate alternative effective and adaptive solutions. This involves identifying skills that have been taught and working on client motivation to use the skills.

Problem-solving and solution-analysis strategies are woven throughout this treatment and involve a detailed examination of the problem behavior accompanied by the generation of alternative adaptive responses. The use of a detailed chain-analysis monitoring form in this treatment (see Chapter 3, Appendix 3.6) helps clients to identify the events and factors leading up to and following the targeted problem behavior. The solution analysis involves the identification of alternative

adaptive responses (i.e., identifying skills to use). The chain-analysis monitoring form is completed by the client for each instance of targeted problem behaviors and reported on during the homework review section of the session.

Stylistic Strategies

Therapists conducting this treatment balance a responsive and empathic communication style conveying warmth and understanding with an irreverent style delivered in a matter-of-fact manner. One or the other is used moment to moment in sessions, depending on what the situation calls for. Responsive, empathic communication is usually most appropriate when assisting the client to accept him- or herself and to help him or her to move out of negative self-judging. The matter-of-fact communication is a strategy to help get a client who seems unable to see things from a different perspective to become "unstuck." The irreverent communication strategy is designed to gently shock or wake the client up by being quite frank and honest with her or him, thus helping the client to get moving. For example, if a client says "I couldn't keep practicing the skills because they were taking too much time," the therapist, with a humorous tone, may say, "Ah—I get it. Practicing the skills took up too much time … but you *were* able to fit in time for a binge," or "If you had time to binge, you had time to practice the skills."

Motivation and Commitment Strategies

Eliciting commitment and agreements from clients is an ongoing task for therapists throughout treatment. The first agreement clients make is to come to treatment. The next is to agree that the goal of treatment is to stop binge eating, and the next is to learn and practice the skills. Therapists constantly gauge a client's level of commitment, using motivation and commitment strategies as commitment waxes and wanes.

In DBT, motivation is not viewed as an internal state or an intrinsic quality of the client. Instead, therapists understand the necessary role of situational variables that, when present, increase the likelihood that clients will exhibit a desired behavior (i.e., be "motivated"). Therapists also keep in mind that eliciting commitment and agreement from a client is an ongoing job that requires therapists to constantly gauge the client's current level of commitment, returning to the motivation and commitment strategies as the client's commitment waxes and wanes.

In standard DBT, group skills training focuses on remediating clients' deficits in capability, whereas individual treatment helps clients identify applications of the newly taught skills to everyday situations and also involves analyzing motivational issues that may interfere. This analyzing may take the form of a behavioral chain analysis or a solution analysis, or it may involve using commitment strategies.

The challenge for therapists conducting this adapted DBT treatment is to provide in one session both the motivational component usually focused on during individual treatment in standard DBT and the skills training usually taught in group skills training (see also Chapter 3). It is the job of therapists to cheerlead clients in using skills in difficult situations. When clients give up, the therapist should not assume that clients either can or cannot solve problems for themselves.

Wherever possible, the therapist needs to work on "dragging out" new behaviors in clients in these situations.

Commitment strategies are discussed briefly here and throughout the relevant sections of this book. Again, readers are also referred to Linehan's text (1993a, particularly pp. 284–291) as essential reading. Evaluating Pros and Cons involves helping the client review the advantages of whatever behavior is being evaluated, as well as counterarguments to those advantages. The therapist should highlight the short- and long-term consequences of the pros and cons. For example, behaviors that look attractive in the short run may have very negative sequelae. In Playing the Devil's Advocate, the therapist counters or challenges the client in a way that results in the client's providing his or her own reasons that he or she *must* change. In the Foot-in-the-Door technique (Freedman & Fraser, 1966), the therapist enhances compliance by first asking for something easy, followed by something more difficult. In the Door-in-the-Face techniques (Cialdini et al., 1975), the therapist first makes a challenging request followed by an easier one. In Connecting Present Commitments to Prior Commitments, the therapist reminds the client of previously made commitments to bolster a commitment that may be waning or when the client is behaving in ways that are inconsistent with previous commitments. The strategy of Highlighting Freedom to Choose in the Absence of Alternatives enhances commitment by emphasizing the client's choice to do whatever he or she wishes while highlighting the lack of effective alternatives.

Treatment Team Consultation Strategies

The primary strategy here is a weekly meeting of therapists. The purposes of these team consultation meetings are (1) to review and evaluate adherence to the protocol; (2) to "treat the therapist" by providing a nonjudgmental environment for each therapist to observe and describe his or her own behavior, thoughts, and feelings regarding the week's sessions and for other team members to provide nonjudgmental feedback, validation, and suggestions for change; and (3) to discuss how best to handle any therapy-interfering behaviors on the part of any group members or clients receiving individual therapy.

Structural Strategies

Treatment is structured or organized around the specific targets outlined in the treatment target hierarchy (Chapter 3, Appendix 3.2). The targets include both problem eating behaviors that must stop and the skills that must be learned in order to accomplish this. By orienting clients to the skills being taught and how to use them, the therapist bridges the gap between the client's goal of stopping binge eating and the client's learning of the new skills. For example, the therapist might say: "OK—so this is what you can do when you're feeling depressed if you don't want to feel that way. Opposite action means doing the opposite of what your mood is telling you to do. So the opposite of depression—which tells you to withdraw and to stay inactive—is getting active." Therapists give clear instructions as to how clients can apply the skills being taught rather than assuming that clients possess this ability.

STRUCTURE OF GROUP SESSIONS

As described briefly, this adapted treatment combines elements of the functions of two distinct modalities in standard DBT: individual psychotherapy (enhancement of motivation) and group skills training (acquisition/strengthening of new skills).[2] With much to accomplish, each 2-hour weekly group session should start on time, whether or not all group members are present. Therapists begin by greeting the group. If a group member arrives late or has missed a previous session, she or he is asked to briefly state what occurred as part of her or his turn during the homework review. This attention to behavior that interferes with receiving treatment is very important, and absences or late arrivals should not be ignored. But after this brief attention, therapists should move on. If a group member is not present and is expected, one of the cotherapists may call to check in and encourage the client to attend the group. With clients who are repeatedly absent or late, group leaders should use their judgment and may wish to address this privately with the group member in a brief phone call or an in-person meeting. If necessary, a chain analysis will be performed targeting this therapy-interfering behavior.

Homework Review: Diary Cards and Chain Analyses

Chapter 3 discusses the structure of the homework review in greater detail. Briefly, the first half of each session (50 minutes for group sessions, 25 minutes for individual sessions) is devoted to a review of the past week's skills practice and chain analyses conducted on targeted behaviors. In the group format, each group member should have about 5 minutes to report on her or his use of the new skills and to describe specific successes or difficulties in applying the skills to replace problem eating behaviors. The therapists check with each group member to make sure she or he can explain what skills were used, how she or he used them, and whether they were effective. Group members should be encouraged to help one another identify solutions to problems encountered in applying the skills and to "cheerlead" the efforts each fellow group member makes.

Therapists clearly convey that each group member will be asked about her or his skills practice and that the member will be questioned about skills not practiced. This serves to motivate clients to use the skills at some point during the week so as to have something to share. Clearly stating that each member will be asked to share each week sets the norm for practice and can be a source of motivation. Therapists should be alert to the possibility of a group member feeling "stu-

[2]Although our data are based on the structure used in our research trials, wherein BED treatment was delivered over 20 weekly 2-hour group sessions and BN treatment over 20 weekly 50-minute individual format sessions, there are no data to suggest that changing the delivery method would adversely affect clinical outcomes. Indeed, Telch's case report (1997b) demonstrated good response in a client with BED receiving treatment via individual sessions. Therefore, therapists treating individuals with BED or BN may administer the treatment in either a group or individual format. Similarly, although our research studies tested 20 treatment sessions, differences between research and clinic settings may require therapists to cover the material at a different rate. Chapters 3–7 focus on the skills to be taught, not on the time allotted for the therapist to teach them. For therapists wishing to replicate our studies, the appendix to this book outlines the specific content covered in each session.

pid," ashamed, or embarrassed about sharing and can discuss which of the skills would be useful to practice in this circumstance.

Because a very limited amount of time is available, therapists should help clients to be very focused. Chapter 3 offers more guidance. Briefly, clients are asked to report on two items. The first is a report of their practice of the skills during the prior week and their use of skills to replace maladaptive binge eating and other problem eating behaviors. The basis for this sharing about skills practice is the diary card, which each client is expected to have completed. The second item is the client's report on the chain analysis conducted on the targeted eating behaviors. Each client reports on the target behavior highest in the hierarchy (Chapter 3, Appendix 3.2). For example, if binge eating and/or purging—the highest targets—occurred, the client must report on the chain analysis of that behavior. If binge eating and/or purging occurs, it is important for therapists to keep in mind the concept of dialectical abstinence (Chapter 3) to help clients fail effectively so that they can get back up and make a commitment to never binge again from this moment on. If binge eating and/or purging did not occur, the next target on the hierarchy would be discussed.

In the homework review, the client is asked to report on (1) a key dysfunctional link identified on the path to the problematic behavior (see Chapter 3 for details) and (2) what skill or skills they could have used and will try to use next time to replace that dysfunctional link.

For clients having difficulty with skills practice and application, therapists need to assess the nature of that difficulty. For example, first determine whether the problem is due to a lack of understanding of the skill, to a lack of skill practice, or to motivational factors. If the problem is due to a lack of understanding, a brief review—ideally offered by another group member—may be indicated. If the client understands the skill, determine whether greater strengthening is needed through additional practice. If so, help the client to set realistic practice goals. If the problem is due to a lack of motivation, the commitment strategies described earlier and given in greater detail in Chapter 3 (and see also Linehan, 1993a) are utilized. For instance, the therapist may have the client review pros and cons of practicing skills, form a plan of action to practice skills, and commit to the plan to overcome obstacles to skills practice (including self-criticism for lack of practice) for the upcoming week. Therapists must be careful not to join in punishing or criticizing the client but help her or him to recommit to practice. Therapists should describe and validate any successes described, as well as failures. This may mean validating how difficult it can be to use the skills under extremely stressful conditions. If therapists are judgmental about group members' difficulties, clients may feel free to share only successes.

Therapists may suggest to clients who repeatedly fail to practice the skills that they use the chain analysis form to analyze this problem. In other words, lack of skills practice is the targeted problem (treatment-interfering behavior) analyzed in detail via a chain analysis. Conducting a chain analysis is a skilled behavior in and of itself, and helping clients to develop this skill is key to adaptive behavior.

Therapists must search for and praise every small approximation of using the skills. For example, therapists can distinguish between the client's attempts to use the skills and the outcome. Praise should be offered for effort, followed by helping

the client analyze what happened, what interfered, and how the client can be more effective with the use of skills the next time.

Therapists should watch for any clients who always use the same skill. In such cases, remind clients that the objective is to develop the ability to use each skill. Once a skill is learned, clients can choose not to use it. But experience with all the skills allows clients to make informed decisions about whether or not a particular skill is best for them given the circumstances.

In summary, problems that come up in the homework review can be addressed by briefly:

1. Formulating hypotheses about the possible factors involved in producing the problem behavior.
2. Generating skills solutions by asking, "What skills could you have used here?"
3. Encouraging group members to commit to trying out the skills solutions suggested.

In our research setting, at the end of the review of skills practice, therapists collect any diary cards, homework sheets, chain analyses, and so forth.

Break

During 2-hour group sessions, a 5- to 8-minute break should take place after the homework review to allow group members to use the restroom, get a drink of water, stretch, and so forth. Inform the group members that the second half of the session will begin promptly to allow a full hour during which instruction and practice of the new skills can take place.

Skills Instruction

In general, teaching each skill involves:

1. Providing an explanation or rationale for including the skill in this treatment program—that is, explaining to clients why this skill is being taught, why it is important, and how it is relevant to clients' goals of stopping binge eating and gaining control over problem eating behaviors.
2. Skill acquisition—describing the skill and specific steps for learning the skill.
3. Skill strengthening—demonstrating how to practice the skill and providing opportunities to practice that skill during the group sessions.
4. Skill generalization—providing suggestions for using skills during daily life. Therapists should enlist clients in generating ideas about how skills can be used to replace binge eating and other problem behaviors when emotions are dysregulated.

The teaching of skills is facilitated by the use of handouts and homework materials. The idea is to make learning the skills relevant to clients' lives. To make sure

group members are active and involved in the discussion, therapists should ask questions that check for skill comprehension and to enlist ideas for skill utilization. To facilitate comprehension, therapists should focus on making a few key points, using the remainder of the time to illustrate with metaphors and stories, to reinforce, or simply to rephrase those key points.

At the end of the session, therapists should clarify and review the homework for the upcoming week. This involves describing homework sheets and making sure clients understand how to practice and record the skills. Then, during the session's final minutes, a wind-down is offered. This involves a few minutes of practicing a specific skill (e.g., diaphragmatic breathing).

In conclusion, there is a great deal to cover in each session, with very little time to do so. Therapists must therefore be flexible, using skillful means to be effective rather than trying to be perfect. When necessary, therapists must be willing to give up making each and every point during instruction of a skill if the situation calls for spending more time on a client's question. Alternatively, if the therapist feels the skills training will suffer as a result of omitting a point, the therapist might offer to discuss the question over the break. The idea is to always keep one's eye on the prize—helping clients stop binge eating by teaching adaptive skills when emotions are dysregulated.