

TREATMENT OF EATING DISORDERS

BRIDGING THE RESEARCH-PRACTICE GAP



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Healing Self-Inflicted Violence in Adolescents with Eating Disorders

A Unified Treatment Approach

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Self-inflicted violence (SIV) in adolescents with eating disorders (ED) is a daunting treatment challenge requiring the integration of various clinical approaches. This chapter provides a definition of such behavior and explores its underpinnings, appreciating the factors contributed by both nature and nurture. A unified approach is proposed to treat both ED and SIV using a modified addiction model that blends Dialectical Behavior Therapy (DBT) (Linehan, 1993a, 1993b) with a 12-step model. This integrated treatment model examines the impact of SIV not only on the individual, but on peers and caregivers as well. The proposed model strives to provide a more complete therapeutic approach to best help those adolescents struggling with both ED and SIV.

DEFINITION AND SCOPE OF THE PROBLEM

“Violence” is a term that evokes strong connotations of physical force, abuse, and destruction. As suggested by Mazelis (2002), the term self-inflicted violence (SIV) will be used to describe the gamut of self-injurious behaviors in which individuals engage. This characterization avoids colluding with the denial and minimization inherent to this psychiatric population, their peers, and sometimes their parents and caregivers as well. Utilizing this term more accurately describes the behavior directly and explicitly identifies the ways in which patients turn against themselves in acts of violence.

Most people imagine an adolescent cutting him or herself with a razor when they hear the term “self-injurer.” The range of covert self-injurious behaviors is broad and may include: cutting, skin-picking, hair pulling, head banging, burning, inserting objects under the skin, nail biting, scratching, piercing, and tattooing, to name a few. Eating disorders can be seen as forms of SIV, as starvation, over-exercise, bingeing, purging, and compulsive

overeating are all acts of violence on the body. On a broader spectrum, drinking, smoking, and drug abuse are included as forms of self-injurious behavior (Favaro & Santonastaso, 2000). Patients can also use other activities in ways that are violent or self-deprecating which fall under the general rubric of covert self-abuse (e.g., sexually compulsive behavior or over-working).

A major distinction between overt and covert forms of SIV is the immediacy and tangibility of the former. Favazza (1996) further distinguishes compulsive from impulsive self injury. Compulsive SIV tends to be more closely associated with obsessive-compulsive disorder and includes such behaviors as skin-picking and scratching. Impulsive self injury occurs in response to an emotional trigger, usually brought on by an interpersonal experience. The functions of SIV can include self-punishment, expression of feelings of anger, and release of overwhelming emotions (Ross, Heath & Toste, 2009). Over time, SIV consumes the patient's identity, overshadowing and drowning out her authentic personhood, much like the progression of addictions and ED.

For the purposes of this chapter, we will focus on SIV as defined by any overt act which violates social and cultural norms and results in direct physical harm to one's body in the absence of *conscious* suicidal intent. We will use the terms SIV and self injury interchangeably. Although some have made a case for self injury to be classified as its own disorder (Favazza, 1996), it is most accurately diagnosed as an Impulse-Control Disorder Not Otherwise Specified according to the DSM-IV-TR (American Psychiatric Association, 2000).

There is significant overlap between the SIV and ED populations, which may point to some common underlying etiologies. The demographics of these populations are broad, including adolescent girls and boys, adult men and women (some with onset of ED and/or SIV during adulthood), and people of a variety of educational levels, socioeconomic class, and professions (Levitt, Sansone & Cohn, 2004). Up to 50% of patients with SIV have histories of ED (Svirko & Hawton, 2007). Co-occurring self injury is also very common in patients with ED. The literature estimates that between 20 and 40% of adolescents and women with ED engage in some form of SIV (Paul, Schroeter, Dahme & Nutzinger, 2002). However, not all adolescents with ED engage in SIV outside of their eating behaviors. Of note, the research on ED with co-occurring SIV largely neglects the most common ED population—Eating Disorder Not Otherwise Specified (EDNOS). The prevalence of SIV tends to be higher in patients with purging behaviors, but not at a level of statistical significance in most studies (Cassin & von Ranson, 2005).

Patients with ED and SIV are stigmatized in both professional and lay communities. One of the functions of the "difficult to treat" labeling of SIV patients is to help treatment providers maintain distance from their transference feelings. Labeling also blinds clinicians to the adaptive function of SIV and their identification with this population. Opening a clinician's eyes to these truths will lead to the closeness and understanding necessary for the development of an effective healing relationship. As human beings, we have all engaged in myriad and subtle forms of self-neglect. Operating from a non-judgmental stance offers patients the compassion and acceptance that they desperately need. This patient population is exquisitely sensitive to the difference between experiential knowledge and book knowledge. The gap between providers talking the talk and walking the walk may be tragically reflected in the recidivism and stigma associated with adolescents who self-injure.

UNDERPINNING: TRAUMA

Feelings, emotion, somatic memory, trauma, sensuality, and sexuality are all human experiences. Many patients with an ED and SIV have a history of childhood abuse, neglect, or interpersonal chaos in the home environment (Paul et al., 2002). Self injury later in life is strongly associated with histories of early childhood sexual abuse (Van der Kolk, Perry & Herman, 1991), but not all self-injurers have such histories. Adolescents with ED and SIV desperately need a daily means to release and regulate their seemingly unmanageable emotional experiences (Ross et al., 2009; Wildes, Ringham & Marcus, 2009). Eating disorders and self injury in part represent an avoidance response that becomes generalized to all emotions, especially for patients who have come to experience all emotions as re-traumatizing. Since adolescence is a developmental stage rife with uncertainty, identity diffusion, and intense emotions, the SIV can soon become a trusted ally and stable pillar of the adolescent's identity.

The brain areas connected to PTSD in patients are relevant to memory and affect regulation. The hippocampus plays a critical role in the formation of verbal or declarative memory. It is not uncommon for patients with PTSD to have limited declarative memory of their trauma, which is likely to be related to the neurotoxic effect on the hippocampus of high levels of stress hormones released during traumatic experiences. Over-activity in the amygdala has also been found in patients with histories of trauma and PTSD (Shin, Rauc & Pitman, 2006). The amygdala is an area of the brain involved in emotion regulation, particularly with fear. Dysfunction in emotion regulation correlates clinically with a patient's experience of having overwhelming, intense fear states (Shin et al., 2006). The impact of traumatic experiences on any areas of the brain tends to be more significant during periods of rapid development in childhood and early adolescence.

Nature

Research has revealed evidence for genetic underpinnings for ED. Multi-family linkage analysis studies have found associations of genes on specific chromosomes with anorexia nervosa (AN) and bulimia nervosa (BN) (Bacanu et al., 2005; Devlin et al., 2002; Grice et al., 2002). Other studies have examined the association of certain genetic markers with traits common to ED or SIV, such as perfectionism or impulsivity. Serotonergic deficits have been observed in studies of spinal fluid and peripheral blood in patients with impulse control disorders (including those who self-injure), in patients with AN and BN, and in those with histories of childhood abuse (Steiger et al., 2004). Dopamine reward circuitry has been studied most intensively with populations addicted to drugs and alcohol. Evidence is emerging from functional imaging studies showing similar activity of the reward pathway for patients with the so-called process addictions (including compulsive overeating and compulsive self injury) when exposed to "using cues" (Coletta et al., 2009). Patients who self-injure or purge also set up a reward circuitry in order to become dependent on the endorphin release associated with acute physical harm. As in substance addictions, the phenomenon of tolerance develops and more ED or SIV behavior is necessary to maintain the effects of achieving a state of calmness, numbness, and/or well-being.

Each individual has a biological susceptibility at the receptor level in the brain's reward center which determines the amount of relief experienced after using one type of self-destructive coping mechanism compared to another. This influences the patient's unhealthy coping behavior of choice, which they turn to when faced with limited resources and overwhelming life experiences. For example, bingeing and purging does not "work" for everyone who attempts to use it for release, escape, or emotion regulation. Similarly, SIV doesn't leave most people feeling safe, in control, or free from pain. These types of coping mechanism develop in certain genetically and neurophysiologically vulnerable people who have a need for them—those with limited support facing uncontrollable and overwhelming circumstances.

Nurture

In addition to the biological underpinnings, SIV can have its roots in psychosocial causes (Linehan, 1993a). Learning effective emotion regulation and self-soothing skills begins in the first year of life. When developmental needs are not met, individuals learn to regulate their emotions through external measures. In the case of SIV, these measures are visceral actions taken against the body (Ross et al., 2009). This developmental disruption can be the result of many factors, including the environment in which the patient was raised. In some cases, an abusive or neglectful environment is at the base of developmental arrest. In homes with alcoholic or mentally ill parents, for example, children may not consistently receive the attention or modeling of emotion regulation that they require. The experience of abandonment, in one way, shape, or form, is common to patients with SIV.

In addition to the abusive or neglectful environments of some teenagers with emotion dysregulation, other teens may have been raised in "normal" households but were simply mismatches with the parenting styles of their caregivers. This "goodness of fit" theory has been explained in great detail elsewhere (Chess & Thomas, 1986; Thomas & Chess, 1985), and remains an important consideration when attempting to understand the causes behind the arresting of emotional development in teenagers. In situations where parents are unaware of the differences in one child's emotional needs, or cannot adjust styles to meet that child's needs, the child grows up in an invalidating, even if well-meaning, environment.

Regardless of the reason, when children are raised in environments where the acknowledgment and expression of emotion was not fostered, they do not learn how to depend on their own internal guidance to identify and properly act on feelings (Linehan, 1993a). This externalized locus of control requires teenagers to look to outside sources so as to understand how they are feeling—leading to significant problems, especially in unpredictable environments. In emotionally minimizing environments, they may need to continually express more heightened responses to get their needs met (Linehan, 1993a). Additionally, because they are unable to trust their internal responses, patients with external locus of emotional control depend on messages from others to "know" how they are feeling. This type of relationship is a set-up for patients to base their sense of self solely on what others think. Without a positive self-regard and internal locus of control, motivation for treatment and change is understandably low. Modeling these qualities to our patients can be the most effective tool for motivation enhancement.

IMPACT: PATIENT AND ECOLOGICAL SYSTEM

The impact of SIV is deep and multi-faceted. In addition to its physical and emotional toll on a patient's well-being, SIV casts a large net of pain and disruption on their entire ecological system, including family members, school peers, romantic partners, and significant others.

For the SIV patient, self injury is a trauma in and of itself. Overt SIV results in a physical wound as the body is literally under assault at the hands of its owner. The wounds may require medical attention, and, if left unattended, can become infected and result in larger, more serious health problems.

The physical trauma of SIV is, however, largely symbolic of the intangible psychological trauma lying underneath the bodily wounds. While trying to regulate emotion through SIV, patients are re-sending a message to themselves that they are worthless or deserving of physical attack. The shame and secrecy of SIV contributes to the psychological trauma; as with active ED symptoms (binging, purging, restricting), SIV is frequently done in solitude. This time spent in self-destructive seclusion contributes to their isolated state of mind as well as missed opportunities to learn to modulate emotions in the context of a healing community.

The developmental impact of SIV on teenagers is far-reaching. As with other trauma, developmental progress is halted at the time of the trauma (Trickett & McBride-Chang, 1995). Precious time is lost to self harm, leaving less of it for other aspects of teenage life. Their social development lags in regard to friendships and romantic relationships, important milestones of these years. A vicious cycle of loneliness and alienation ensues. Teens that self injure have more reluctance to form positive peer relationships and report fewer positive peer experiences than those who do not (Ross et al., 2009). Sexual development and exploration as appropriate to these years is avoided, delayed, or changed as the attack on the body can be used to dissipate feelings of sexual tension and to avoid or deny sexual feelings. In addition, the stigma associated with SIV may cause other parents to disapprove of relationships with affected teens.

Academic achievement can also be stymied due to an inability to complete work when overwhelmed with emotions, or when active symptoms or treatment needs interfere with attendance. Teachers may have little experience with SIV and may not be prepared to best support the student in their classroom. Similarly, SIV patients may experience negative impacts in their work life. Bosses may not understand what exactly is happening, and may not be prepared to support an employee with such symptoms. In short, the developmental impact of SIV can be catastrophic and reaches into every aspect of a typical teen's experience.

The family unit is rocked when a member engages in SIV. Family routines become disrupted by the SIV events, treatment, and fears of what is yet to come. As focus increases on the SIV, family dynamics can become strained, and other pressing problems neglected. Treatment can financially strain a family. Parents can become overwhelmed with anxiety about their own problems or from blaming themselves for contributing to and not being able to "fix" the SIV. Alternately, parents can experience avoidance and denial of the problem, thereby giving room for the SIV to continue unchecked. As the family focus becomes hyper-attuned to the SIV patient, other siblings may begin to feel left out.

Finally, the friends and significant others of patients who engage in SIV are also affected. In intimate relationships, the boyfriend or girlfriend may feel impotent to help. Close friends can also feel this way, and might try to avoid discussing the problem or avoid the friend entirely.

RECOVERY DEFINED

In order to define recovery from SIV, the following questions must be addressed: what is the therapeutic task? How are we authorized to help? What is our role in the process of recovery? The therapist's task is to support and facilitate the process of recovery. At its core, the healing work is about connecting on a physical, emotional, and spiritual level with our patients. Recovery is not as simple as stopping the ED or SIV behaviors (see McGilley and Szablewski, Chapter 12). Families and treatment providers may be as confused and frightened by SIV as the patient. The more others try to make a patient's behaviors stop, the more shame they swallow about their powerlessness over using SIV for comfort. In the absence of an honest acknowledgement of the benefits that SIV or ED symptoms serve, and a gentle and loving approach to addressing the roots of earlier traumatic experiences, there will be little hope for long-term recovery.

Being mindful of the benefits and costs of SIV as a coping mechanism, understanding the profound despair and pain of patients using it, and trusting in the process of recovery are the therapeutic tasks—not trying to fix, manage, and control patients or their choices. Approaching the work with ED/SIV patients as a trusted servant rather than a force of change keeps the therapist's job manageable and transmits a sense of manageability to a patient who may be starving for it. Once they have hit bottom, patients are best supported by the therapist being present and returning responsibility for recovery back over to them. Through acknowledging powerlessness over the patient's disease and choices, and focusing on what is controllable, therapists become open to seeing their true power and channeling their energy to good use. One of the most useful ways therapists serve patients is by believing in them until they can believe in themselves, caring for them until they can care about themselves, and loving them until they can love themselves (Mazelis, 2002).

While recognized recovery programs exist for other forms of addiction, those who self injure tend to have more difficulty finding support from positive group identification. An important caveat to the dearth of community support is Self Mutilator's Anonymous (SMA), whose mission statement reads:

A fellowship of men and women who share their experience, strength, and hope with each other, that they may solve their common problem and help others to recover from physical self-mutilation...The only requirement for membership is a desire to stop mutilating oneself physically. There are no dues or fees for SMA membership. We are self-supporting through our own contributions. SMA is not allied with any sect, denomination, politics, organization or institution; does not wish to engage in any controversy; neither endorses nor opposes any causes. Our primary purpose is to stop mutilating ourselves and to help others to recover from self-mutilation. (<http://www.selfmutilatorsanonymous.org>)

SMA has begun the difficult work to become a recognized recovery and support network for those moving through their SIV recovery. Its philosophy is based on that of other 12-step

programs (<http://www.12step.org/>), which offer ongoing support and a spiritual path to life-long recovery (see [Appendix A](#)). Despite SMA's importance and promise as a growing recovery community, currently only 20 live meetings in North America and three on-line meetings are listed on the national website.

In addition to the limited number of mutual support group meetings, those in the process of recovering from SIV confront many other obstacles. Just as the symptoms are stigmatizing, taking steps to confront and overcome SIV also carries a stigma. While alcoholism and substance abuse recovery is not shame-free by any means, it is more widely recognized since most people know active or recovering alcoholics and/or addicts. Few people know patients who compulsively engage in SIV, much less those who are open about their recoveries.

Recovery is typically a long-term process requiring intensive, specialized treatment. The tedious pace of recovery is itself good medicine for the impulsivity and urgency that otherwise characterizes the disease. Inadequate treatment, in terms of amounts or pacing, is a major cause of relapse in the ED/SIV population. Limited access to care presents further obstacles to recovery. Persisting through these obstacles, and maintaining a non-judgmental, and compassionate stance allows providers to effectively join patients and their families in their healing journeys. Patients who have successfully recovered from other addictive disorders, their treatment providers, and family may not view the SIV as a primary treatment issue to be addressed. Additionally, some patients express fatigue from recovery of other disorders and/or prioritize maintaining their recovery in, for example, their ED or alcoholism.

A UNIFIED TREATMENT APPROACH FOR PATIENTS WITH ED AND SIV

The benefits of a unified approach for this population are manifold; facilitating integration and unity are the roots of healing. Piece-meal treatment approaches with this vulnerable population risks giving them a mixed message, and, at worst, may increase their sense of disintegration and identity diffusion. A unified, experiential approach combining dialectical behavioral therapy (DBT) ([Linehan, 1993a](#)) and 12-step facilitation with their inherent philosophies of acceptance and change provides a unique way to facilitate integration and healing for this patient population. In a unified DBT recovery model, we integrate specific steps of 12-step recovery with the principles of DBT. Three core tenets of this approach are described below.

Dialectics of Step One

At the heart of a harm-reduction model is the acknowledgment of benefits of both the SIV and ED. However, there is a critical distinction between acknowledging the benefits and enabling self-injurious behavior. Some therapists will steer clear of any recognition of the benefits of SIV for fear of supporting the behavior. [Linehan \(1993a\)](#) found that without a balance of acceptance and change strategies, patients feel invalidated by the therapist and are less likely to engage in treatment. A clinical example illustrates this point. An older adolescent with a history of sexual trauma in childhood was in recovery from binge-purge type AN for 1 year. She began to engage in daily hair pulling and cutting in the pubic

area. Although ashamed and embarrassed about it, she was not ready to stop. According to the stage of change model (Prochaska & DiClemente, 1983), she was in the contemplation stage.

The adolescent was given a homework assignment to take an inventory of the behavior (step four in a 12-step model of recovery). The assignment consisted of a written inventory of 25 positives and negatives of engaging in her SIV, and to read it at the next session with her therapist (step five). This assignment incorporates the dialectic in DBT (i.e., costs/benefits of the behaviors), as well as the concept of radical acceptance (from the therapist and within the patient). An excerpt of what she wrote follows:

Positives: It feels really good; it numbs my feelings; it helps me fall asleep; it helps me avoid eating; I feel a little high during and after; it gives me a sense of control; it gives me a sense of power; it gives me a reason for my shame; it's less dangerous than bingeing and purging; it helps me feel less lonely.

Negatives: Scarring; I get trapped in it; I feel shame about it; I'm abusing my body; it separates me from God; it's time-consuming; I feel depressed afterwards; I isolate during and after; I can't stop even when I feel like I want to; I feel broken afterwards.

The therapeutic pillars of this exercise included the relief associated with honesty, shame reduction, and self-disclosure. Further, it represented a practical demonstration of the delicate balance between acceptance and change strategies when working with patients who are ambivalent. The Acceptance/Change dialectic underlying DBT treatment is captured by the Serenity prayer: "God/Goddess/Higher Power, grant me the serenity to accept the things I cannot change, the courage to change the things I can, and the wisdom to know the difference." The dialectic in the serenity prayer boils down to acceptance of being powerless over the disease, while still taking responsibility for recovery by tapping into the real power inside themselves to change and heal.

Radical Acceptance

Another core principle of DBT is the concept of *Radical Acceptance* (Linehan, 1993a), which is similar to step one's principles of honesty and acceptance. Patients are supported in understanding and acknowledging that they suffer from a disease they did not ask for, and that, without help, can ruin or end their lives. Therapeutic focus is placed on what they *can* change—accepting their past and who they are in the present. Choices are identified and emphasized, the most important of which is whether or not to remain committed to recovery.

Willingness

The distinction between willingness and willfulness is another core tenet of an integrated DBT recovery approach. Willfulness is characterized by acting without regard to known adverse outcomes. It involves a lack of surrender to the "wise mind," and a rigid hanging onto old ways of thinking and behaving regardless of outcome (Linehan, 1993a). The mind of an untreated addict in distress will always take an immediate over a longer term reward, even if the latter is much bigger. During intense emotional states marked by hyperactivity of the amygdala and decreased activity in the frontal lobes, the patient loses the ability to "play the tapes forward." DBT skills, particularly mindfulness, and the use of the group or

a sponsor in 12-step programs offer a means to re-engage the frontal cortex, which is essential for executive functioning, impulse inhibition, planning, and decision-making. One of the most powerful moments to witness is when a patient recognizes for the first time that a thought of, “I should cut myself,” is just a thought and not an imperative. Through mindfulness, patients learn to identify thoughts as thoughts and emotions as emotions, and choose responses to these stimuli that align with their wise mind (Linehan, 1993a; Miller, Rathus & Linehan, 2007).

Willingness and open-mindedness are essential in the recovery process. Patients are encouraged to ask themselves, “Am I willing to experiment with different ways of coping?” “Am I willing to take responsibility for my choices and actions?” These qualities are captured by the second and third steps of the 12-step recovery model (see Appendix A), and the DBT skills of acting opposite to emotion, and often times opposite to the compulsion, cravings, and urges which arise in states of emotional arousal (Linehan, 1993b).

A full discussion of medication interventions used in the ED and SIV populations is beyond the scope of this chapter. Both for ED and SIV, medication is really an adjuvant treatment. Research supports only a limited role for medications in the treatment of ED and SIV (see Levine and Levine, Chapter 7).

Implementing a Unified Approach with Teens

Implementing DBT in a residential setting can be a difficult task. In outpatient DBT programs, commitment is obtained from every participant and is the basis for all further treatments. For example, when a client presents with resistance, the therapist is able to redirect the client using their commitment as an acknowledged foundation to the treatment and creating a life worth living (Linehan, 1993a). This approach allows for a greater dialectical dance of acceptance and change to occur within the therapeutic relationship. Adolescents in residential settings are not often in treatment willingly, but rather as a result of their parents’ and treatment provider’s consensus. Creating a “buy in” for these patients presents a challenge. Although there is no easy answer to this lack of self-motivated interest, it is possible to engage patients through flexible and determined skills lessons. The primary path to engagement in DBT skills training for adolescents is employing experiential techniques that lie within Linehan’s philosophy of dialectics, validation, and non-judgmental skills coaching.

Offering two DBT sessions per week helps balance the didactic skill lessons with experiential exercises. One session is a didactic presentation teaching Linehan’s (1993b) four skill areas: *Mindfulness*, *Emotion Regulation*, *Interpersonal Effectiveness*, and *Distress Tolerance*. In the second session, the focus is on learning or practicing the skills in creative ways, such as using art to solidify the week’s lessons. For example, in the Emotion Regulation Handout 3, “Life of an Emotion” lesson (Linehan, 1993b, p. 137), patients learn about what happens when they experience emotions (from the prompting event, to internal and external experience, to labeling emotion name, to the aftereffects). In the initial session, Handout 3 (Linehan, 1993b, p. 137) is reviewed and group members give examples of how their emotions and reactions to emotions fit into the cycle. In the subsequent session, in groups of two or three, residents create their own version of Handout 3, using a representative piece of poster-sized work for each step of the cycle (e.g., Prompting Event, Interpretation of Event, Emotion Name). At the end of the group meeting, residents share their work with each other,

explaining how that step fits in with the rest of the cycle. (See [Appendix B](#) for an example of this experiential group's artwork.) After completing this exercise, adolescents are expected to demonstrate an understanding and synthesis of the Emotion Regulation skills presented.

In addition to art projects, role-playing and skits offer adolescents experiential learning opportunities. Interpersonal effectiveness and distress tolerance skills lend themselves nicely to such techniques. Most adolescents are able to identify several real-life situations that ended negatively due to their inability to use pro-social relationship skills or effectively tolerate distress. Using these personalized examples, adolescents are encouraged to role play alternative endings using Linehan's DEAR MAN Interpersonal Effectiveness skill or various Distress Tolerance skills (e.g., ACCEPTS, IMPROVE, Self-Soothe; [Linehan, 1993b](#)). Through this interactive skill building method, group participants practice and experience how these skills apply to their particular life, so that they become more familiar and accessible when needed.

Another technique to engage the adolescent's skill building is to offer an "advanced" training group to residential patients willing to make the commitment to using and practicing mindfulness and DBT skills ([Miller et al., 2007](#)). Patients in this advanced group attend another weekly group, as well as receiving individually tailored skills training. As they display progress in their treatment, the advanced group's effectiveness becomes visible to other patients and increases their motivation to engage in both general and advanced groups.

Teaching mindfulness to teens can present another roadblock to adolescent engagement in DBT. It is highly unfamiliar for adolescents used to continual stimulation from multiple inputs to focus on a single task for any length of time. However, this obstacle is usually quickly overcome through validation and setting clear limits around participation. Once expectations are set for each group to begin with a mindfulness exercise, older group members will acquaint the newer members with the guidelines of the activities. Mixing more active mindfulness activities (playing telephone or a game of musical chairs) with the more traditional (focusing on the breath or describing an object) expands teens' means of mindful presence ([Miller et al., 2007](#)). As patients develop in their mindfulness skills and repertoire, encouraging them to lead the mindfulness practice at the beginning of the session can further engage both willing and reluctant participants.

Getting creative and employing experiential techniques while sticking to the philosophy of DBT can be enjoyable for both group members and leaders. Additionally, for those lacking initial commitment, it has the added benefit of keeping adolescents engaged and learning new skills. The combination of experiential methods, an advanced group, and group leaders' unwavering dedication to continued mindfulness practice, sets the stage for meaningful participation and skills building.

Milieu Treatment

As problems with SIV and ED will have developed within the context of a patient's family, friends, and environment, patients must transfer their new skills to these familiar relationships and situations. In outpatient programs and residential settings, family involvement in groups has proven to be a successful addition to adolescent DBT trainings and skill building ([Hollander, 2008](#); [Miller et al., 2007](#)).

Milieu therapy is a unique element of inpatient and residential treatment. Throughout the day, residents may encounter different situations (meals, conflict with peers, upsetting group topics, etc.) that elicit emotional arousal. Treatment providers are around at all times, providing patients with opportunities to get “on the spot” skills coaching in many different contexts (Holmes, Dykstra, Williams, Diwan & River, 2003).

A challenge for milieu treatment is ensuring that active symptoms are not inadvertently reinforced. It can be triggering for a resident to see others who self-injure. Competition issues can evolve, especially for those who have used their eating behaviors or SIV to gain needed attention. Having others use those same methods can feel threatening to adolescents, who might turn back to SIV to ensure that their needs will continue to be met by the staff. Thus, it is important to have a structured milieu setting with specific approaches designed to not inadvertently reinforce SIV. For example, a careful balance must be struck between responding to any incidents of SIV without providing positive reinforcement; if the only time a patient feels that his or her emotional needs are getting met by staff is when he or she self-injures, then logically the patient will want to continue to self-injure. However, if incidents of SIV are met with matter of fact care and attention while lavish praise and attention is given to more positive coping skills, the positive skills will be quickly reinforced on the unit both for patients who self-injure and for the rest of the milieu (Holmes et al., 2003).

On the other hand, exposure to peers with similar symptoms can be a source of enormous support to suffering teens. In addition to the previously noted benefits of a 12-step program, the milieu can provide a similar type of peer understanding and help. Residents will be in varying stages of recovery, from first-time treatment seekers to those in longer-term recovery journeys. In time, they begin to trust one another, engender mutual hope and learn from the collective group experience. For example, a resident may often see in others what she cannot see in herself, and can care about others in a way that she does not yet care about herself. Likewise, her peers can do the same for her. These are potent occasions of therapeutic mirroring and reciprocity.

While the milieu setting is an excellent environment for laying the recovery groundwork, transitional planning is vital for successful long-term outcome. As patients develop and practice coping skills and the 12 steps in the milieu, situations must be continually introduced to expose them to greater approximations of the environment to which they will return (Holmes et al., 2003). It is important to keep a comfortable tension between creating confidence and familiarity in skills already learned, and presenting new learning opportunities.

IMPACT OF SIV ON TREATMENT PROVIDERS

Self-inflicted violence can be a difficult and daunting clinical presentation for many clinicians, especially when combined with a comorbid diagnosis of an ED. Staff at both residential and community treatment centers face distinct challenges when providing care to multi-impulsive adolescents. The effects of vicarious traumatization (VT) on healing providers have been well-documented in the scientific and clinical literature (Sabin-Farrell & Turpin, 2003).

Anger and frustration regarding a client’s progress, or lack thereof, are common experiences of VT. These feelings can arise out of the provider’s sense of hopelessness regarding

the client's improvement, as well as self-doubt regarding their own effectiveness (Linehan, 1993a). Additionally, feelings of loss of control, or of not being able to fully guarantee a patient's safety, are typical in residential or community based providers (Holmes et al., 2003). The word "manipulation" gets tossed around frequently when working with the ED/SIV population, and the stigma surrounding SIV is perpetuated. Treatment providers are susceptible to projective identification and can end up carrying some of the patient's pain avoidance. To steer clear of their own pain and limitations as therapists, they may distance themselves from the SIV population. This, at its core, is counter-therapeutic.

Difficulties associated with VT underscore the importance of following the DBT framework, which stresses regular consultation with clinicians who treat similar populations (Hollander, 2008; Linehan, 1993a). Consultation agreements, one of the tenets of DBT work, provide a framework with which to approach the care both of clients and of other providers (Linehan, 1993a). Consultation groups can acknowledge and provide the support needed for working with this difficult-to-treat population. Peer support also helps clinicians recognize any of their own covert or overt SIV, and provides an avenue of accountability in those areas. Similarly, clinicians are encouraged to attend their own 12-step support groups. Al-Anon, for example, can be a very useful way to help staff learn how to take care of themselves while caring for others.

An individual mindfulness practice is an additional self care tool for therapists who treat ED/SIV patients. Mindfulness allows individuals to begin to see their own thoughts and judgments without reaction (Kabat-Zinn, 1994). This naturally extends to interactions with clients as well. Practitioners become more aware and forgiving of themselves and others, and better able to slow down their reactions to discern if they are being helpful and effective in their interactions (Shapiro & Carlson, 2009; Wilson & Dufrene, 2008).

CONCLUSIONS

Treating adolescents who struggle with both SIV and ED is an intimidating challenge for even the most experienced provider. The impact of SIV and ED reaches beyond the identified patient to her family, environment, and treatment team. The suggested unified approach that blends DBT with a 12-step model allows the patient, family, and provider to address these problems on physical, emotional, and spiritual levels, setting a framework from which integrated recovery can be achieved.

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APPENDIX A

Twelve Steps of Self-Mutilators Anonymous

(<http://www.12step.org/>), as adapted by authors

- Step 1 We admitted we were powerless over our self-mutilation—that our lives had become unmanageable
- Step 2 Came to believe that a Power greater than ourselves could restore us to sanity
- Step 3 Made a decision to turn our will and our lives over to the care of God as we understood God
- Step 4 Made a searching and fearless moral inventory of ourselves
- Step 5 Admitted to God, to ourselves and to another human being the exact nature of our wrongs
- Step 6 Were entirely ready to have God remove all these defects of character
- Step 7 Humbly asked God to remove our shortcomings
- Step 8 Made a list of all persons we had harmed, and became willing to make amends to them all
- Step 9 Made direct amends to such people wherever possible, except when to do so would injure them or others
- Step 10 Continued to take personal inventory and when we were wrong promptly admitted it
- Step 11 Sought through prayer and meditation to improve our conscious contact with God as we understood God, praying only for knowledge of God’s will for us and the power to carry that out
- Step 12 Having had a spiritual awakening as the result of these steps, we tried to carry this message to others, and to practice these principles in all our affairs

