

HARBOURING CHANGE: COLLABORATIVE CONTINGENCY MANAGEMENT IN MED-DBT FOR MULTI-PROBLEM EATING DISORDER PRESENTATIONS

Anita Federici



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01	Contingencies Are Already Happening
02	Why ED Behaviors Persist
03	When Contingencies Go Wrong
04	Reinforcement Traps in Practice
05	Using CM in MED-DBT: Practice & Application

If it's not changing, it's being reinforced.

AGENDA



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CM IS NOT ABOUT CONTROL.

It is about building a shared system that stabilizes behavior while protecting the relationship.



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MEET GIORGI

- Recurrent ED, suicidality, self-injury, substance use, trauma
- Multiple hospitalizations, minimal progress
- Rapid cycle: discharge → destabilization → readmission
- Wears hospital bracelet to session:

“I’ll probably be back anyway.”



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WHAT KEEPS HAPPENING

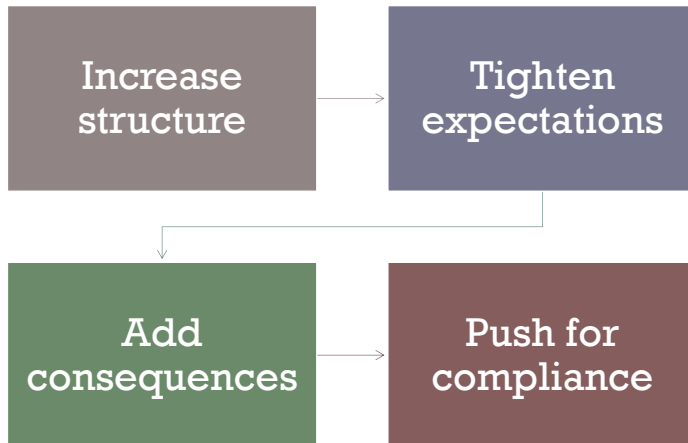
Crisis → hospitalization

Stabilization → discharge

Discharge → rapid relapse

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And most of that... doesn't work for long.

WHAT DO WE
USUALLY DO
HERE?

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WHAT IS CONTINGENCY MANAGEMENT?

- Behavior is shaped by contingencies (if → then)
- Focus on *antecedents* + *consequences*
- Behavior is learned → can be unlearned

CM in MED-DBT:

- Not standalone
- Done *with* clients, not to them



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CONTINGENCIES ARE ALWAYS OPERATING.

**The question is not whether we use them,
but whether we use them skillfully.**



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GIORGI – WHAT
MIGHT WE BE
REINFORCING?

- Restriction → hospitalization
- Hospitalization →
 - care / attention
 - relief from demands
 - predictability
 - permission to eat
 - sense of belonging

The system may reinforce the behavior we're trying to stop.

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WHY CM MATTERS IN EDS



- ED behaviors are **not random**
They are **multiply reinforced**:
 - Biology
 - Emotions
 - Environment
 - Culture



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WHY THIS MATTERS

- If a behavior works → it persists
- Insight does not compete with reinforcement
- Reinforcement is powerful, immediate, long-standing
- Change requires modifying reinforcement systems

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WE'VE ALWAYS USED CONTINGENCIES... SO WHY CHANGE?

What clients know:

- “If I don’t eat → I lose privileges”
- “If my weight drops → I get escalated”
- “If I’m honest → I may be discharged”

CM is often experienced as:

- punitive
- rigid
- non-collaborative



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SO WHAT?



You are competing with years of powerful reinforcement



Behavior change will fail if we don't target what's reinforcing it

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SHIFT IN MED-DBT

From controlling behavior → To mapping and modifying reinforcement patterns

From punishment → To strategic, collaborative reinforcement

From symptom reduction → To building a life worth living

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WHY CM BREAKS DOWN IN ED CARE

Why CM Breaks Down in ED Care

- Contingencies are already everywhere...but:
 - Inconsistent → confusion
 - Team disagreement → polarization
 - Emotional responding → drift
 - Patient experience → coercion
- **Without alignment: teams burn out**

Inconsistent contingencies reinforce the problem.

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GIORGI + THE SYSTEM

- Recurrent ED, suicidality, self-injury
- Multiple admissions, minimal progress
- Rapid cycle:
discharge → relapse → readmission
- Wears hospital bracelet:

"I'll probably be back anyway."

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WHAT THE SYSTEM DOES

Across providers:

- Different responses to same behavior
- Limits shift depending on context

Between sessions:

- Distress → increased access
- Hospitalization → system mobilizes



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WHAT GIORGI LEARNS

“If I escalate, the system organizes around me”

“Limits depend on who I’m with”

“Distress changes expectations”

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WHAT THE TEAM EXPERIENCES

- Confusion (“What are we doing?”)
- Disagreement (“too rigid / too soft”)
- Emotional responding (fear, urgency, frustration)
- Drift from the model
- Burnout + polarization

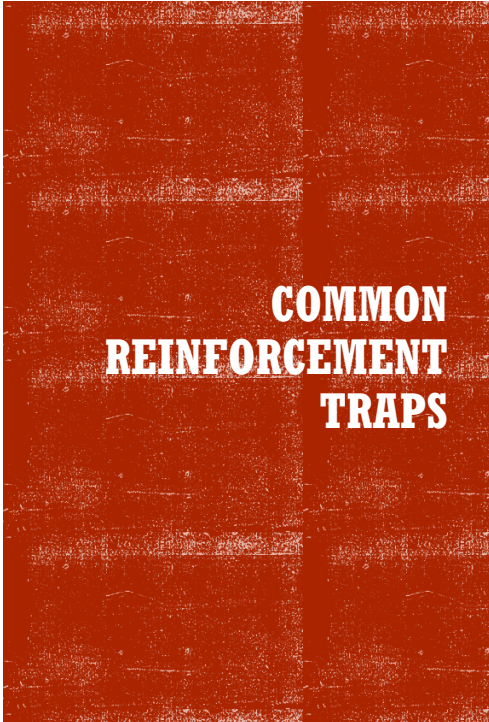
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Contingencies are:

- Already present
 - Emotionally driven
 - Inconsistently applied
- *Inconsistent contingencies don’t just fail— they train the pattern.*

THE CORE PROBLEM

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Avoidance Gets Reinforced

- Meal not completed → expectations lowered
- Dysregulation → escape
- Avoidance → relief → strengthened

Severity Gets Reinforced

- Weight loss → attention
- Crisis → access
- Instability → system mobilizes

Symptoms Create Connection

- Not eating → deeper processing
- Struggle → warmth increases
- Behavior → contact + care



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- Therapist anxiety → softened limits
- Inconsistency → loopholes
- Warmth tracks struggle more than progress
- Validation without direction → no change required

WE ARE ALWAYS SHAPING BEHAVIOUR.

The question is whether we are doing it *intentionally*.



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BEFORE YOU USE CONTINGENCY MANAGEMENT

1. Understand the Reinforcement Landscape

- ED behaviors are *highly reinforced* (need contemporary understanding of biological, emotional, social, cultural)
- Behavior \neq random \rightarrow identify what *maintains it*
- What reinforces one client may not for another

2. Separate Intent from Consequences

- What the client *means* to do \neq what actually reinforces the behavior
- Focus on *functional outcomes*, not stated goals



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BEFORE YOU USE CONTINGENCY MANAGEMENT

3. Check Your Own Reinforcers

- Therapist behavior can unintentionally reinforce ED symptoms
- Watch for weight bias, discomfort with tension/conflict, expectations around emotion management, selective attention, cultural bias, lack of ASD-affirming interventions

4. Avoid Assumptions → Be Curious

- No universal contingencies
- Collaboratively *map reinforcement patterns* with the client



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5. Prioritize Collaboration (Not Control)

- CM should feel *empowering*, not punitive
- Shift from “compliance” → *skill-building and choice expansion*

6. Lead with the Relationship (GIVE skills)

- Validate + stay gentle and dialectical
- Avoid threat-based framing (“if you don’t... then...”)



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- A consequence that increases the likelihood of a behavior.
- Purging → relief → reinforced
- Restriction → reduced anxiety → reinforced
- Crisis → attention → reinforced
- Relief is one of the most powerful reinforcers we have.

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- **Positive reinforcement**
→ adding something (attention, warmth)
- **Negative reinforcement**
→ removing something (anxiety, distress)
- Most ED behaviors are negatively reinforced



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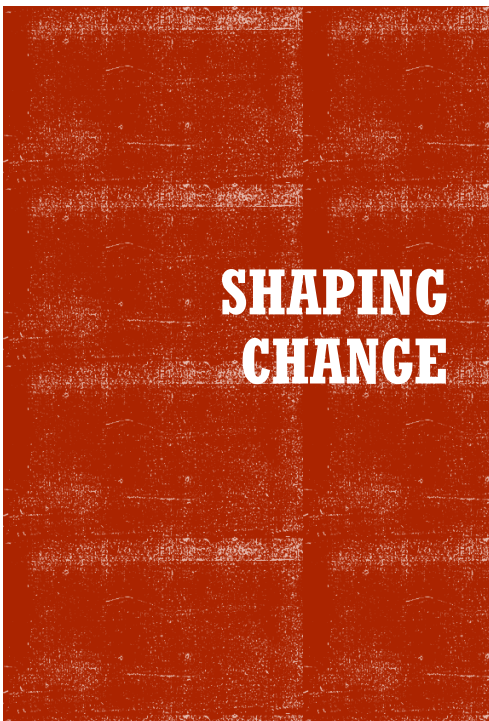
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- Punishment = decreases a behavior (but often creates new problems)
 - Honesty → criticism → ↓ honesty
 - Meal refusal → consequences → ↑ covert behavior
 - Disclosure → increased monitoring → ↑ avoidance
- *Punishment often reduces visibility, not the behavior itself.*

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Reinforce **small steps**, not just outcomes:

- Partial meals
- Showing up
- Skill attempts
- Honesty

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- Behavior decreases when reinforcement stops BUT:
 - ED behaviors have multiple reinforcers
 - Extinction is rarely clean

Expect:

- escalation
- distress spikes
- “it’s getting worse”

This is where most teams abandon the plan.



EXTINCTION

(AND WHY IT'S MESSY)

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GENERALIZATION

- Learning must transfer across contexts:
 - inpatient → outpatient
 - session → home
 - therapist → family
- If contingencies change across settings, the behavior is unlikely to change.

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A CLINICAL MOMENT

- A patient lies frequently to providers and family about ED and other target behaviours. Avoids disclosure of symptoms. Seen as “manipulative” and “not trustworthy” by staff and family.
- What’s the function?



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LET'S ADD CONTEXT

- Patient discloses pacing behaviour to parent
- Parent responds*:
 - refuses to visit
 - expresses disappointment
 - says: “it’s always something with you”

* Not “parent is the problem” – rather, this is what happens in high-stakes systems under stress



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IMMEDIATE AFTERMATH

Patient sobbing

Urges to self-harm ↑

Says: “See... this is why I lie.”

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WHAT IS BEING REINFORCED?

- Honesty → punished via criticism or, withdrawal
- Lying → negatively reinforced (short-term)

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Dialectical Behavior Therapy and Eating Disorders: The Use of Contingency Management Procedures to Manage Dialectical Dilemmas

Wisniewski, Lucene, PhD; Ben-Porath, Denise D, PhD . American Journal of Psychotherapy ; Washington Vol. 69, Iss. 2, (2015): 129-140.

[ProQuest document link](#)

ABSTRACT

Several researchers have adapted and/or applied dialectical behavior therapy (DBT) for populations with eating disorders. There is a growing body of research that indicates that DBT is an effective treatment option for this population, including those who have co-occurring Axis II disorders. The goal of the current paper is to summarize the research conducted in the area of DBT with those individuals who present with eating disorders only as well as those who present with both eating disorders and Axis II disorders. We also describe a dialectical dilemma, apparent compliance vs. active defiance, which is commonly observed in the group with comorbidities A DBT

“THE THERAPIST’S JOB IS NOT TO IMPOSE CONTINGENCIES, BUT TO HELP THE PATIENT DETERMINE WHETHER THEIR CURRENT CONTINGENCIES ARE MOVING THEM TOWARD OR AWAY FROM THEIR GOALS.”



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CM is Not:

- compliance-based
- therapist-imposed
- about control

We are:

- helping clients **observe contingencies**
- helping them **evaluate effectiveness**
- helping them **modify patterns**

Goal: Not to make behavior change
→ but to help clients understand how behavior works

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LWL FOCUS



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Orient client to:

- Contingencies already shaping behavior
- Patterns can be modified

Use:

- Curiosity (“What reinforces this?”)
- Collaboration (“How do we change it?”)
- Wise Mind

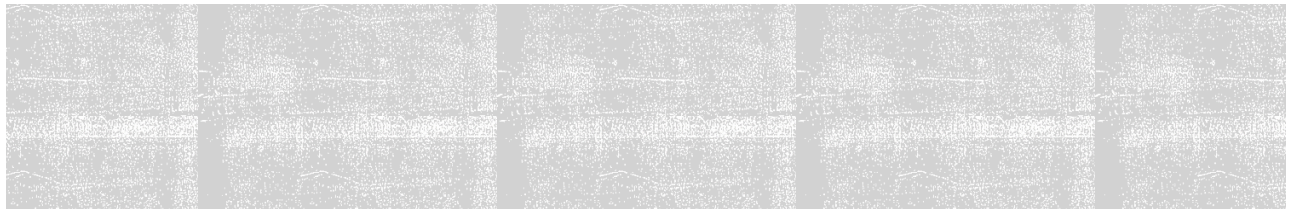
Increase awareness of:

- Reinforcement patterns (past data)
- Alignment with life worth living goals

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PATIENTS SET THE CONDITIONS UNDER WHICH CARE INTENSIFIES OR DECREASES.



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- Without this:
 - contingencies feel arbitrary
 - patients experience control / punishment
 - ↑ testing, defiance, concealment
- With this:
 - contingencies become predictable
 - patients have ownership
 - ↓ need for apparently compliant or defiant behavior
- When the system is unclear, patients adapt to survive it. When the system is clear, patients can work within it.

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WHAT THIS PREVENTS

- Collaborative contracting reduces:
 - “apparently compliant” behavior (adapts to look like they’re meeting expectations)
 - “actively defiant” behavior (adapts by pushing against them)
 - Learning to navigate less effectively in unclear systems
- Because:
 - the rules are not hidden
 - the consequences are not shifting
 - the ownership is shared
- When contingencies are co-created, there is less need to fight or work around them.



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Reinforcing What Works

- Reinforce small, target-relevant behaviors
- Tailor to the individual
- Use attention, warmth, respect

(Giorgi):

“I’m really glad you came today.”



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GIORGI

- Leaves you a voice message
- Sobbing, high distress
- Says she told her mother about ED behavior and now mom won't come to see her, says she is disappointed, "its always something with you"
- Is distraught – I don't know what to do, nothing matters. Nothing will ever change.

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IDENTIFYING INADVERTENT REINFORCEMENT



- If behavior persists → it's being reinforced often by:
 - attention
 - over-engagement
 - flexibility

What would accidental reinforcement sound like with Giorgi?

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- In session she tells you she bought laxatives, already took 4 each day on the weekend
- “I don’t care anymore, they just punish me when I try to be honest”
- Is tearful, wants to talk about things her mother said to her and how hurt she feels
- She has an opportunity to attend college in the fall → “what’s the point in that? I can’t get better. I feel broken!”
- “No point taking my hospital bracelet off”
- “What would *accidental reinforcement* sound like here?”

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AVERSIVE CONTINGENCIES

Used when:

- reinforcement isn’t enough
- behavior is entrenched

Includes:

- extinction (removing reinforcement)
- disapproval / limits
- strategic consequences

Must be:

- intentional
- not emotional



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GIORGI

- In session she tells you she bought laxatives, already took 4 each day on the weekend
- “I don’t care anymore, they just punish me when I try to be honest”
- Is tearful, wants to talk about things her mother said to her and how hurt she feels
- She has an opportunity to attend college in the fall → “what’s the point in that? I can’t get better. I feel broken!”
- “No point taking my hospital bracelet off”

- What would it sound like to *not reinforce* these statements?

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USING YOUR RESPONSE AS A CONTINGENCY

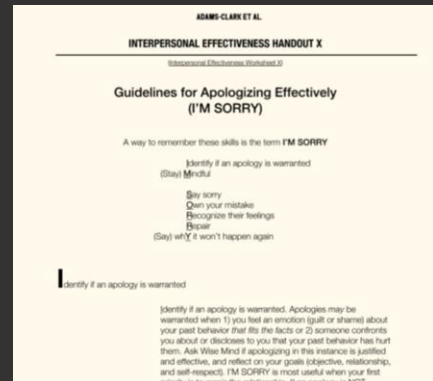
- Your warmth is a reinforcer
- You can:
 - lean in (reinforce)
 - step back (withdraw)
- “Tell me more...” (reinforcing)
- “That’s useful data.” (neutral/withdrawing)

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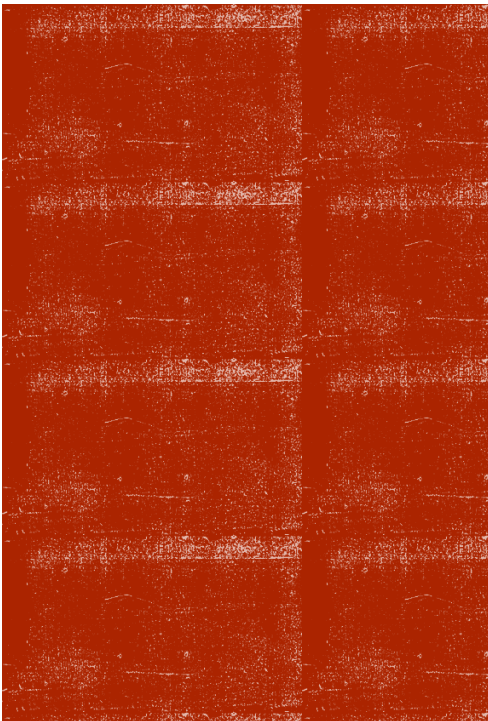
CORRECTION– OVERCORRECTION

When target behavior occurs:

- Acknowledge impact
- Repair (correction)
- Change the pattern (overcorrection)
- Reinforce engagement



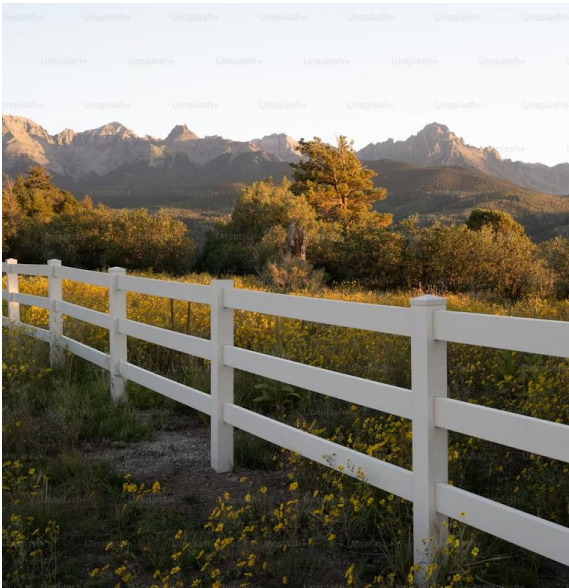
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- Giorgi attends another session and is very upset. Says she has been accused of abusing a staff. Reported that she had stopped using/buying laxatives but was counting on prescribed laxatives. When she was with nurse practitioner earlier today, told they were not going to give prescribed laxatives either at this time, she felt panic and anger and pushed the nurse's cart into her legs, causing her pain. Client extremely distressed. Told the family health team would be reviewing her behavior and may “write this up”.
- What is this behavior *doing* for Giorgi in the moment?

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OBSERVING LIMITS

Limits:

- are clear
 - fluid
 - shape behavior
 - protect the relationship
- “I can’t continue treatment under these conditions.”
- What is a clear, non-punitive limit?



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- Used in treatment impasses – Last resort
- Function:
 - motivate change through pause
- Requires:
 - clear targets
 - time frame
 - rationale
- Not abandonment or discharge → strategic pause with conditions
- What conditions would need to be met for Giorgi to return?



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KEY TAKEAWAYS

- CM is already happening
- ED behaviors are reinforced
- Function > form
- Therapists are part of the system
- Reinforcement is primary
- Aversives are used carefully
- Correction builds change
- Limits matter



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If you want to learn more.....



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Special Issue

Emerging Therapeutic Interventions for Eating Disorders Through Psychology



Guest Editors

Dr. Anita Federici

Deadline

20 September 2026



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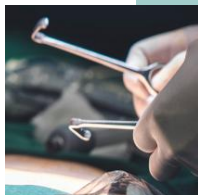
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