**INTRODUCTION**

Family-Based Treatment (FBT; Lock et al., 2001) has been shown to be effective in the treatment of adolescent Anorexia Nervosa (Lock et al., 2010), yet a subset of patients fail to adequately respond to this approach. In particular, those with high parental expressed emotion, co-morbid psychopathology, and poor therapeutic alliance show less responsiveness to FBT (Eisler et al., 2000; Lock et al., 2006; Pareira et al., 2006). Our clinical experience also suggests that co-occurring suicide ideation and/or self-harm behavior complicates the treatment of adolescent eating disorders (EDs), though research on this phenomenon and its impact on treatment is limited. Thus, there is a need for a treatment that can more effectively address the above issues while simultaneously targeting the eating disorder.

The success of Dialectical Behavior Therapy (DBT) to treat complicated patients with high levels of emotion dysregulation may be a viable option for adolescent patients with complex ED presentations (Salbach-Andre et al., 2008). Recent studies have offered support for the use of modified DBT approaches for adults with bulimia nervosa and binge eating disorder (Chen et al., 2008; Safe et al., 2010). While promising, the majority of these interventions were designed for adults with low to moderate illness severity and did not incorporate the full DBT model. In recent literature, case studies using DBT with multi-diagnostic adolescents with EDs have shown significant improvements in both adolescents’ behavioral symptoms of EDs and symptoms of general psychopathology (Salbach-Andre et al., 2008). Overall, however, there is a paucity of research on the effectiveness of DBT for multi-diagnostic adolescents with EDs who fail to respond to standard treatment protocols.

This poster describes a novel DBT intensive outpatient program (IOP) designed for adolescent patients with EDs who have not responded adequately to standard FBT and who present with suicidal and self-injurious behavior, comorbid mood disorders, and/or high emotion dysregulation. The program, currently being implemented at a specialized ED tertiary care facility, integrates standard adolescent DBT (including DBT individual therapy, multifamily skills training, telephone coaching, and consultation team) with FBT techniques (e.g., family-focused care, focus on weight gain and medical stability) that are well established for the treatment of AN.

**WHAT IS DIALECTICAL BEHAVIOR THERAPY?**

- Developed by Marsha Linehan (1993) to help people struggling with chronic suicidal and self-injurious behaviors
- Based on the idea that impulsive and self-destructive behaviors are caused by an inability to manage intense emotion
- Blends cognitive behavioral approaches (e.g., CBT) with meditative practices and acceptance strategies
- Given DBT’s success, evolved into a treatment for people with emotion dysregulation may play a central role (e.g., eating disorders, PTSD)

**WHY DBT FOR EATING DISORDERS?**

DBT is based on an emotion regulation model.

**的重要事实关于情绪和饮食障碍：**
- 许多个体与一位ED报告称他们有困难的情绪在健康的适应性方式
- 没有充足的情感调节技能，ED症状可能导致情绪的过度调节/无法忍受的感觉
- 正面情绪可能是一个触发器来处理饮食障碍
- 如果感到紧张和情绪调节可能影响到脆弱的青少年

**WHAT IS FAMILY BASED TREATMENT?**

**DBT AND FBT: Conceptual Overlap**

Both treatment modalities use a nonjudgmental stance towards the family: FBT takes a non-blaming stance towards the family in regards to the etiology of the ED, thus reducing parental guilt and increasing parental engagement in treatment (Lock et al., 2001). DBT labels behaviors that occur within the family system as invalidating rather than labeling familial invalidating environments, thereby reducing parental perceptions of incompetence and increasing the likelihood for all family members to engage in treatment (Miller et al., 2007).

Both treatment modalities strongly advocate for empowerment of the client: DBT empowers parents as competent relapsing agents for their children, and empowers the adolescent to achieve appropriate developmental milestones (Lock et al., 2001). DBT advocates for a “consultation to the client” approach, in which therapists as as ‘consultants’ to help clients and families find ways to communicate effectively with others, as negotiating their needs on their own is a vital life skill (Miller et al., 2007).

**HOW DBT AND FBT APPROACHES WORK TOGETHER IN THE DBT IOP**

- **Weekly Individual Therapy**: A DBT therapist and family therapy with the same therapist as needed; occurs outside IOP hours
- **Weekly Multifamily Skills Group**: 90-minute group that uses a classroom format to teach new skills and strengthen existing skills.
- **Parents and adolescents attend together; occurs during IOP hours.**
- **5 modules are taught:**
  - Mindfulness: how to focus on the present moment
  - Interpersonal Effectiveness: how to get interpersonal needs met
  - Distress Tolerance: how to survive a crisis without making it worse
- **Weekly Skills Group:**
  - Refining the Middle Path: how to manage parent-teen dilemmas
- **Weekly Consultation Team:** therapists meet weekly to reduce burnout, provide therapy for the therapist, improve empathy towards the client, and provide consultation on specific client issues
- **Access to Phone Coaching:** brief interactions focused on helping clients apply skills to their specific circumstances
- **Individual Therapist serves as coach for adolescent:**
  - Use of Behavior Chain Workshops: detailed review of thoughts, emotions, and behaviors that happened before, during, and after a symptom
- **Client completes when they engage in self-harm behavior, suicidal behavior, or eating disorder behaviors.**
- **Use of modified Diary Cards (see “Modifications” section to the right).**

In addition, all therapists in this program also have experience working in the DBT model and can draw on FBT principles as needed. The FBT approach will be a strong influence on the treatment if the adolescent is significantly underweight and in the process of recovering. The blend of DBT and FBT approaches will vary according to the needs of the individual adolescent.

**STRUCTURE OF THE DBT IOP**

- **Programming is provided 3 days per week, 3 hours per day**
- **Required 6-month commitment, as change is gradual and time is needed to build a solid foundation**
- **Includes the following interventions throughout the week (in addition to DBT interventions outlined above):**
  - **Target Group: Daily group in which diary cards are reviewed, goals are set, and DBT skills are identified for the adolescent to use to skillfully meet goals**
  - **Goal Setting Group:** Helps patients set goals and generate a synthesis between their and their parents’ goals.
  - **Before group, parents and teens fill out a sheet outlining** (1) the adolescent’s weekly goals (2) contingencies if the adolescent doesn’t meet goals, and (3) rewards the adolescent receives if goals are met
  - **Categories:** appointment, weight, meal plan, food exposure, therapy interfering, and quality of life goals
  - **Use of Behavior Chain Workshops:** detailed review of thoughts, emotions, and behaviors that happened before, during, and after a symptom
  - **Weekly Consultation Team:**
    - **Refining the Middle Path:** how to manage parent-teen dilemmas
    - **Use of modified Diary Cards (see “Modifications” section to the right).**

**REFERENCES**


**MODIFICATIONS OF THE DBT APPROACH FOR ADOLESCENTS WITH EATING DISORDERS**

- **Expanded diary cards:**
  - Monitors intake, emotions, use of skills, ED behaviors (binge eating, purging, restricting, etc.), suicidal/self-harm behaviors, and urges to engage in those behaviors
- **Emphasizes relationship between emotions and ED behaviors**

**CONCLUSIONS**

This poster highlights how DBT may be used with FBT as a possible treatment approach for adolescent patients who are not adequately responding to standard ED treatment and who need a high level of care. Currently, we are evaluating the feasibility and efficacy of the program. It is our hope that this poster may move others to consider using DBT with treatment-resistant patients with EDs and to empirically validate its effectiveness.