DBT Intensive Outpatient Program for Multi-Diagnostic Adolescents with Eating Disorders: Description and Development

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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 subgroup 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 suicidal 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-Andrae 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; Safer 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-Andrae 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 planning of meals; focus on weight gain and medical stability) that are well established for the treatment of AN.

WHO IS THIS PROGRAM FOR?

This program is designed for adolescent clients who meet one or more of the following:

- Have not been helped fully by standard FBT
- Are multi-diagnostic (e.g, co-occurring mood disorder, PTSD, etc.)
- For whom emotion regulation problems are central to their symptoms.
- Have been unable to generalize skills outside of standard treatment
- Present with significant interpersonal conflict

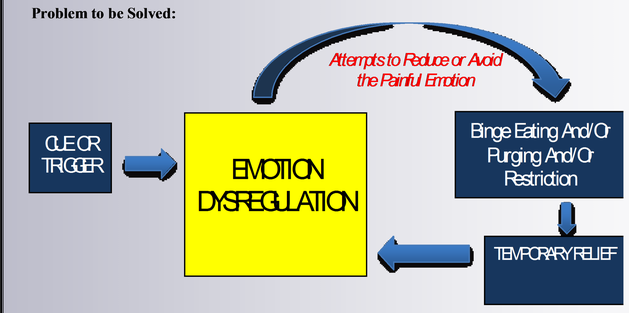
WHAT IS DIALECTICAL BEHAVIOR THERAPY?

- 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 who struggle with other impulsive behaviors for whom 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.

Model of DBT for Eating Disorders



Important facts about emotions and eating disorders:

- Many individuals with an ED report that they have difficulty expressing and managing emotions.
- Many individuals report that they do not have the skills to cope with their emotions in healthy adaptive ways
- Without adequate emotion regulation skills, ED symptoms can become a way of regulating overwhelming/uncomfortable feelings.
- Negative emotions are a very common trigger for eating disorder symptoms.
- If left untreated, emotion dysregulation may increase vulnerability to relapse.

WHAT IS FAMILY BASED TREATMENT?

FBT (Lock et al., 2001) is an outpatient treatment where parents play an active role to help restore their young person's weight to normal expected levels given
age and height. Treatment includes 3 stages:

•**Stage 1:** parents manage the adolescent's meals
•**Stage 2:** the adolescent returns to managing meals
•**Stage 3**: exploration of normal adolescent development issues

FBT opposes the notion that families are pathological or should be blamed for the development of the eating disorder, and considers the parents as an essential resource in the successful treatment of the illness. Further, FBT adheres to the tenet that the adolescent is not to blame for the challenging eating disorder behaviors, but rather that these symptoms are mostly outside of the young person's control (externalizing the illness).

Clinical trials have demonstrated the efficacy of FBT for adolescent AN – approximately two thirds of adolescent AN patients are recovered at the end of FBT while 75-90% are fully weight restored at 5-year follow-up (Le Grange & Lock, 2010).

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 families as 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:**
•FBT empowers parents as competent refeeding 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

The DBT IOP is based on DBT assumptions (e.g., people are doing the best they can, people want to improve, etc.) and incorporates traditional components of DBT for suicidal adolescents, as outlined by Miller et al. (2007):

- **Weekly Individual Therapy** with 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
    - *Emotion Regulation*: how to get more control over your emotions
    - *Walking 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 specific skills to their specific circumstance
  - Individual therapist serves as phone coach for adolescent
  - Multifamily skills facilitator serves as phone coach for parents
- Use of **Behavior Chain Worksheets:** 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 behavior
- Use of modified **Diary Cards** (see "Modifications" section to the right)

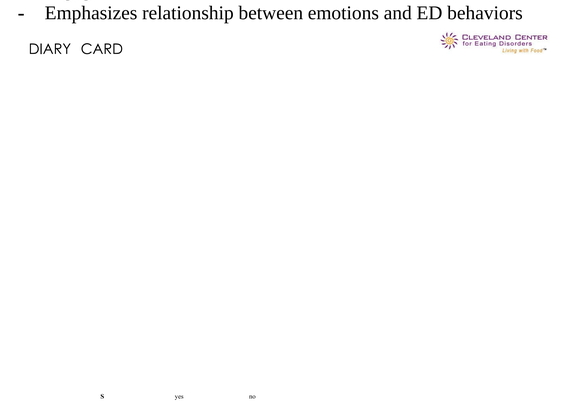
In addition, all therapists in this program also have experience working in the FBT model and can draw on FBT principles as needed. The FBT approach will be a strong influence on the treatment if the adolescent is significantly underweight and in the process of refeeding. The blend of DBT and FBT approaches 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**.
- Requires a **6-month commitment**, as change is gradual and time is needed to build a solid foundation
- Includes the following interventions throughout the week (in additional 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
    - During group, patients work with therapist to generate a synthesis; weekly goals guide daily target goals
  - **Behavior Chain Analysis (BCA) Group**: Group members volunteer each week to do a **BCA** on the board. With the group, a **solution analysis** is generated that provides alternate ways to cope with painful emotions, strong urges, and unhelpful thoughts that can lead to problem behaviors.
  - **DBT in Action:** Allows clients to learn DBT skills through creative expressive activities such as art projects, role-plays, and journaling, and is meant to augment the multifamily skills group.
  - **Meal Support:** Patients eat three meals per week during treatment; one meal is eaten with the entire family.

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



- **Modified hierarchy of treatment behaviors** (Wisniewski & Kelly, 2003) to include ED behaviors:
  - **Target 1: Decrease Life-Threatening Behaviors**, such as:
    - Self-harm/suicidal behaviors and urges
    - ED behaviors that present an imminent threat to patient's life (bradycardia, orthostasis, EKG abnormalities)
  - **Target 2: Decrease Therapy-Interfering Behaviors,** such as:
    - Coming late to sessions, not filling out diary cards, etc.
    - Refusing to be weighed, engaging in behaviors to surreptitiously alter weight, engaging in purging that reduces medication effects
  - **Target 3: Decrease Quality of Life-Interfering Behaviors,** such as:
    - ED behaviors and urges that are not life-threatening
    - Interpersonal problems, co-occurring depression/anxiety, etc.
  - **Target 4: Increase Behavioral Skills** (those taught in skills group)
- Regular contact with a nutritionist (Wisniewski & Kelly, 2003)

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. Presently, we are evaluating the feasibility and efficacy of the program. It is our hope that this poster will move others to consider using DBT with treatment-resistant patients with EDs and to empirically validate its effectiveness.

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