

Dialectical Behavior Therapy Modified for Adolescent Binge Eating Disorder: A Case Report

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Given the lack of empirically supported treatments available for adolescents with eating disorders, it is important to investigate the clinical utility of extending treatments for adults with eating disorders to younger populations. Dialectical behavior therapy for binge eating disorder, based on the affect-regulation model, conceptualizes binge eating as a behavioral attempt to influence, change, or control painful emotional states. With promising research findings in adult women, it is of clinical interest whether the dialectical behavior therapy for binge eating disorder treatment manual could be usefully adapted for an adolescent population. This report describes adolescent-specific modifications (including the use of family sessions) to standard dialectical behavior therapy for binge eating disorder, with an illustrative case study. While more rigorous case studies are needed prior to establishing justification for a randomized trial, this pilot case provides preliminary support for a modified version of dialectical behavior therapy for binge eating disorder as a therapeutic option for adolescents with binge eating disorder.

BINGE eating disorder (BED) and bulimia nervosa are common disorders in adolescents, with estimates of between 1% to 2% meeting diagnostic thresholds for BED and bulimia nervosa and an additional 3% to 5% with significantly disordered eating and weight and shape concerns (see, for example, reviews by Chamay-Weber, Narring, & Michaud, 2005; Schneider, 2003). Although effective treatments for these problems have been identified in adults (e.g., cognitive behavior therapy, interpersonal psychotherapy, dialectical behavior therapy, antidepressant medications; Hay, Bacaltchuk, & Stefano, 2004; Pederson, Roerig, & Mitchell, 2003; Telch, Agras, & Linehan, 2001), few reports include adolescents. In this article we describe how we have adapted a treatment model of dialectical behavior therapy (DBT) for adults with BED to an adolescent population. A case study illustrating our application of the adapted model is included.

DBT for BED is based on the affect-regulation model of binge eating. Drawing on an extensive literature linking negative affect and disordered eating (Abraham & Beumont, 1982; Arnow, Kenardy, & Agras, 1992; Arnow, Kenardy, & Agras, 1995; Polivy & Herman, 1993), the affect-regulation model conceptualizes binge eating as a behavioral attempt to influence, change, or control painful emotional states (Chen & Linehan, 2005; Wiser & Telch, 1999; Wisniewski & Kelly, 2003).

Neither cognitive behavior therapy nor interpersonal psychotherapy, the best-studied treatments for BED to date, focuses on the role of dysregulated emotions in binge eating. While effective, both treatments leave about 40% to 50% of patients symptomatic at the end of therapy (e.g., Fairburn, Marcus, & Wilson, 1993). Because of the number of patients left unremitted, there is interest in developing and researching other theoretical conceptualizations and treatment models for BED. DBT for BED, with its grounding in affect regulation and direct focus on the link between dysregulated emotion and dysregulated eating behaviors, is one such model.

DBT, originally developed by Linehan (1993a, 1993b) as a treatment for borderline personality disorder, is currently the most comprehensive and empirically supported affect-regulation treatment for borderline personality disorder (American Psychiatric Association, 2001). Researchers (Chen & Linehan, 2005; Waller, 2003; Wiser & Telch, 1999; Wisniewski & Kelly, 2003) recognized that DBT's conceptualization of self-injury as a functional (albeit maladaptive) affect-regulation behavior in patients with borderline personality disorder might provide a helpful model for understanding the function (albeit maladaptive) of binge eating as an emotion-regulation behavior in patients with disordered eating.

To date, preliminary studies investigating the adaptation of DBT to target disordered eating have been promising (Safer, Telch, & Agras, 2001a; Safer, Telch, & Agras, 2001b; Telch, 1997a; Telch, Agras, & Linehan, 2000, 2001). For example, 82% of the adult women in an

uncontrolled study of DBT for BED were abstinent (e.g., no objective binge episodes within the last 4 weeks of treatment) after 20 sessions, with none dropping out after commencing treatment (Telch et al., 2000). A subsequent randomized trial found 89% of the participants assigned to 20 sessions of DBT were abstinent compared to 12.5% in the wait-list condition, with 9% dropping out after commencing treatment (Telch et al., 2001).

Given the lack of empirically supported treatments available for adolescents with eating disorders, it is important to investigate the clinical utility of extending adult treatments to younger populations. The decision was made to pilot DBT for BED based on several factors. First, the very promising published findings in adult women with BED coupled with the generally low dropout rates (Telch et al., 2000, 2001) suggested the treatment model to be highly acceptable, an important attribute given the notorious difficulty engaging adolescents in individual treatment. Second, researchers have shown adolescents to be developmentally capable of responding to modified versions of DBT for borderline personality disorder in the outpatient setting (Katz, Cox, Gunasekara, & Miller, 2004; Miller, Glinksi, Woodberry, Mitchell, & Indik, 2002; Rathus & Miller, 2002). Finally, while cognitive behavior therapy and interpersonal psychotherapy for BED have received more empirical support in *adults* than DBT for BED, none of these treatments have been systematically researched in adolescents with BED.

DBT for Adolescent Binge Eating

We adapted the manualized version of DBT for BED (Telch, 1997b), described elsewhere in greater detail (Safer et al., 2001a; Telch, 1997a; Wisner and Telch, 1999). Brief explanations of the DBT for BED treatment components for adults, as well as specific modifications for adolescents, are given in each section below. Using DBT for adult BED to guide treatment length, 21 weekly 60-minute individual sessions were planned. The format of each individual session was modeled after DBT for BED for adults: the first half of each session focused on reviewing the patient's practice of the DBT skills (listed on a weekly diary card) and behavioral chain analysis (described below) from the prior week, and the second half of each session focused on the acquisition of new skills. It was anticipated that some of the 21 individual sessions would be expanded by an additional 30 to 60 minutes to allow for family sessions as clinically indicated.

Orientation to the DBT Model for Binge Eating (Session 1)

As in the adult DBT for BED manual (Telch, 1997b), this session addresses the role of intense emotions in triggering binge eating and is introduced using one of the patient's recent binge episodes as an example to assess the

model's personal relevance. In addition, the patient is introduced to the tool of the behavioral chain analysis—an in-depth examination of a problematic eating behavior, including what triggered the episode, any factors that made the patient particularly vulnerable, as well as the small units of behavior (or the “links” of the chain) that led to the episode (e.g., emotions, cognitions, body sensations, etc.). Patients are also asked to list more skillful behaviors they could use to replace the problem behaviors.

Adolescent-specific modifications to the standard DBT model include meeting conjointly with the patient and parents in the first 15 minutes of the initial session to review the patient's history and to provide an overall orientation to the DBT model and psychotherapeutic goals. Emphasis is also placed on the collaborative nature of the therapy (therapist as “coach”). For example, using one of the patient's recent binge episodes as an example, the therapist works with the patient to demonstrate how to fill out a chain analysis.

Distress Tolerance Skills (Sessions 2 to 5)

Commonly, patients are highly distressed by binge eating. This module (Linehan, 1993b; Telch, 1997b) teaches strategies (e.g., self-soothing, distraction skills, observing one's breath, and accepting reality) to effectively tolerate painful moments or situations that cannot be altered within the moment. One modification of the adult DBT for BED manual is that we presented these skills *first*. This is particularly useful with adolescents because these strategies are quite practical and concrete. A second modification involved helping patients specifically identify ways they can involve siblings, parents, or friends when implementing distressing tolerance skills (e.g., practicing distracting themselves from a strong emotion by asking a sibling to play a game).

Mindfulness Skills (Sessions 6 to 10)

The skills of the Mindfulness Module (Linehan, 1993b; Telch, 1997b) are taught next. These skills increase the patient's ability to be aware of and experience emotions without reacting to them by engaging in emotion-driven eating behaviors. Specific skills include the ability to access a “wise mind”—a synthesis of reason and emotion—and to be able to observe, describe, and participate in the moment (the *what* skills) while being nonjudgmental, focusing on one thing at a time, and emphasizing what is effective versus what feels to be “right” or “just” (the *how* skills). In addition, the patient is taught to eat with awareness (“mindful eating”), to maintain mindful awareness of urges to binge without acting on them (“urge surfing”), and to respect the desire to struggle against family, interpersonal, or societal expectations for thinness without turning to binge eating or other ultimately self-destructive behaviors (“alternate rebellion”).

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