

## Dialectical Behavior Therapy of Anorexia and Bulimia Nervosa Among Adolescents: A Case Series

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*The aim of this study was to describe a case series of adolescents (mean age=16.5 years, SD=1.0) with anorexia nervosa (AN) and bulimia nervosa (BN) who received dialectical behavior therapy (DBT). Twelve outpatients with AN and BN took part in 25 weeks of twice weekly therapy consisting of individual therapy and a skills training group. Family members were involved in the treatment. The patients were compared pre- and posttreatment on behavioral symptoms of AN and BN and symptoms of general psychopathology using standardized instruments (Structured Inventory for Anorectic and Bulimic Syndromes, Eating Disorder Inventory-2, The Symptom Checklist-90-Revised). Posttreatment, significant improvements in behavioral symptoms of eating disorder and symptoms of psychopathology were identified. The application of DBT adapted for the treatment of AN and BN among adolescents was associated with a decrease in behavioral symptoms of eating disorders and symptoms of general psychopathology. However, randomized controlled studies are required to prove the efficacy of this approach.*

**A**NOREXIA NERVOSA (AN) and bulimia nervosa (BN) are severe and often chronic disorders with a high level of physical and psychological comorbidity and high mortality (Fichter, Quadflieg, & Hedlund, 2006; Harris & Barraclough, 1998). BN affects about 1% to 3% of high school- and college-age girls and AN affects about 1% of female adolescents (Faravelli et al., 2006; Kotler, Cohen, Davies, Pine, & Walsh, 2001). Although these disorders mostly begin in adolescence, only a few randomized controlled trials of psychosocial interventions for adolescent outpatients exist.

Cognitive-behavioral therapy (CBT) has been found to be effective in the treatment of BN in adults; however, there is only one published controlled treatment study that specifically targets adolescents with BN (Le Grange, Crosby, Rathouz, & Leventhal, 2007; Wilson & Sysko, 2006). In this randomized controlled study, Le Grange et al. (2007) compared family-based treatment (FBT) and supportive psychotherapy (SPT) for adolescents suffering from BN and found a clinical and statistical advantage for FBT over SPT at posttreatment and at 6-month follow-up.

For adolescent AN, eight uncontrolled treatment trials and five controlled studies exist (Le Grange & Lock, 2005). Most of these studies involved family members and

suggested that family therapy is helpful with younger patients with a short duration of illness. After treatment, 60% to 70% of patients reached a healthy weight (Eisler et al., 2000). Although FBT seems to be the treatment of choice for adolescent AN, Fairburn (2005) levels the criticism that it is still not clear that the effects of FBT are due to involvement of the family or indeed to any property of the treatment. Alternative treatment approaches (which obviously involve the family to a certain extent) need to be investigated and their outcome compared with that of FBT (Fairburn, 2005). With regards to AN treatment, there is a lack of research outside the field of FBT. Psychodynamic treatments and CBT are described in the literature (Bowers, Evans, Le Grange, & Andersen, 2003; Jemmet & Chabert, 1998); however, to date, no systematic evaluations have been performed. In overall terms, there is a need for systematic trials evaluating psychotherapy in adolescents with AN and BN.

Dialectical behavior therapy (DBT) is an empirically supported treatment and was originally developed for female adult multiproblem outpatients diagnosed with borderline personality disorder (BPD; Linehan, Armstrong, Suarez, Allmon, & Heard, 1991). Interest in DBT has grown and researchers have begun to apply DBT to other clinical populations with and without Axis II symptoms (Lynch, Morse, Mendelson, & Robins, 2003; Miller, Rathus, & Linehan, 2007; Rathus & Miller, 2002).

Miller, Rathus, Linehan, Wetzler, and Leigh (1997) and Miller et al. (2007) adapted DBT for suicidal adolescents with borderline personality features. Their

adaptations comprise inclusion of families in skills training groups and conducting family sessions, reducing the length of treatment from 1 year to 16 weeks, simplifying the skills handouts, including skills handout examples that are more relevant to teenagers, and adding a new skills module (Walking the Middle Path) relevant to working with highly dysregulated families (Miller et al., 2007). Wisniewski and Kelly (2003) presented a case for applying DBT to the treatment of patients who suffer from AN and BN. They adapted the biosocial theory and proposed that people who develop eating disorders (ED) may have some biological vulnerability to regulating emotions or to the hunger/satiety system or both. If this biological vulnerability interacts with a specific type of environment (i.e., invalidating environment), the patient may develop an ED. The invalidating environment can occur across a spectrum from a poor fit between the temperament of the individual and her environment to serious physical or sexual abuse. The practical adaptations suggested by Wisniewski and Kelly (2003) include the following: develop ED-specific dialectics (the primary dialectic dilemma as overcontrolled eating versus absence of an eating plan), emphasize ED behaviors in the treatment targets, broaden the diary card, and append a nutrition skills module. Safer, Telch, and Agras (2001), Telch, Agras, and Linehan (2001), and Safer, Lock, and Couturier (2007) adapted DBT for patients with binge eating disorder and BN in their studies. These results showed preliminary evidence suggesting that DBT may be an effective psychotherapy to treat ED in adults.

DBT focuses on helping patients to more effectively regulate their emotions. Because patients with ED often show difficulty regulating emotions and often present with eating pathology (i.e., restricting, binge eating, vomiting), DBT may be viewed as a way to cope with that emotional vulnerability (Safer et al., 2007). The deficits in affect regulation in ED patients are broad in scope and vary between AN and BN. Patients with BN struggle with emotion intensity and dyscontrol (Telch & Agras, 1996), while AN patients have difficulties with identification and awareness of emotions, and avoid emotions to an extreme extent (Casper, Hedecker, & McClough, 1992).

The inherent structure of DBT is a good model for treating patients with ED. It provides a clear behavioral hierarchy that guides therapists in targeting interventions. Suicidal and nonsuicidal self-injurious behaviors (Target I), which are not uncommon in AN and BN adolescents, are addressed first; behaviors that interfere with the therapy (Target II) are discussed next, followed by quality-of-life-interfering behaviors (Target III). DBT includes specific techniques for working with variable commitment to change. AN and BN patients often have difficulties in modifying symptoms, and may be less responsive to

traditional therapeutic interventions, which often are perceived as controlling. Thus, the DBT telephone skill coaching can be used with ED patients to assist in averting dysregulated eating behavior. Finally, weekly consultation team meetings keep clinicians motivated and enable helpful input and feedback around the applied treatment (Wisniewski & Kelly, 2003).

To date, only one study exists on the effectiveness of DBT for adolescent patients suffering from AN and BN (Salbach et al., 2007). This pilot study evaluated the effectiveness of DBT for *inpatient* adolescents. The results indicate that DBT appears to be a promising treatment for inpatient adolescents with ED. To the best of our knowledge, no study has yet examined whether an *outpatient* DBT intervention is feasible and effective at reducing symptoms of AN and BN among adolescents.

## Method

### Participants

Twelve female adolescents (6 with AN and 6 with BN) were recruited from a child and adolescent outpatient psychiatric department of a major university hospital in Germany. All met the criteria outlined in the *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV, American Psychiatric Association, 1994)*, and all were of German origin. All participants included in the study were between 12 and 18 years of age. At the time of entry to this study, subjects could not be in other treatments relating to their ED. Permission to undertake the study was approved by the Institutional Review Board. All subjects received a written notification form that outlined the project and inclusion/exclusion criteria of the study. Participants under 18 years of age could only participate in the study if they and their parents gave written informed consent. Before treatment, the following psychiatric comorbidities were diagnosed with the Composite International Diagnostic Interview (CIDI, German version; Wittchen & Pfister, 1997) and the Structured Clinical Interview for DSM-IV Personality Disorders (SCID-II, German version; Fydrich, Renneberg, Schmitz, & Wittchen, 1997). Three patients met the *DSM-IV* criteria for major depression, four met criteria for minor depression, one for panic disorder, one for histrionic personality disorder, and one for borderline personality disorder. During the trial, one subject initiated antidepressant treatment. Detailed information on patients appears in Table 1.

### Measures

The Structured Inventory for Anorectic and Bulimic Syndromes (SIAB-EX; Fichter & Quadflieg, 2001; Fichter, Herpertz, Quadflieg, & Herpertz-Dahlmann, 1998) was used to assess the prevalence and severity of specific

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