

Description of an Intensive Dialectical Behavior Therapy Program for Multidiagnostic Clients With Eating Disorders

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The authors describe an intensive outpatient dialectical behavior therapy (DBT) program for multidagnostic clients with eating disorders who had not responded adequately to standard, empirically supported treatments for eating disorders. The program integrates DBT with empirically supported cognitive behavior therapy approaches that are well established for the treatment of eating disorders. Attention is given to inclusion and exclusion criteria, how the program differs from standard treatments for eating disorders, and the application of specific DBT treatment components for multidagnostic clients with eating disorders.

Keywords: dialectical behavior therapy, eating disorders, borderline personality disorder

Even with the availability of well established, empirically grounded eating disorder treatments (e.g., cognitive behavior therapy, interpersonal psychotherapy, traditional day treatment), a substantial number of individuals with eating disorders fail to make adequate treatment gains, require repeated hospital admissions, or terminate treatment prematurely (Wilfley & Cohen, 1997; Wilson, Fairburn, & Agras, 1997). Researchers have speculated that clients with eating disorders who do not respond to standard treatments are more likely to (a) have a comorbid Axis I or Axis II disorder (Johnson, Tobin, & Dennis, 1990); (b) enter treatment with a more severe clinical picture in terms of eating pathology and general emotional distress (Wonderlich, Fullerton, Swift, & Klein, 1994; Zeeck et al., 2007); or (c) exhibit greater emotion dysregulation, interpersonal deficits, and impulsivity (Bruce & Steiger, 2005; Fichter, Quadflieg, & Hedlund, 2006).

The lack of treatment response to traditional approaches to eating disorders is believed to be due, in part, to the failure of traditional cognitive behavioral interventions to adequately address the pervasive emotion dysregulation and skill deficits present in this unique population (Becker-Stoll & Gerlingoff, 2004; Zeeck, Herzog, & Hartmann, 2004). Furthermore, traditional treatment protocols for eating disorders were not designed to simultaneously treat chronic suicidal and self-injurious behavior, ongoing therapy-interfering behaviors (e.g., arriving late to treatment, water loading on weigh-in days, not completing homework), or pervasive personality pathology in the context of a severe eating disorder. Thus, several researchers have stated that clients with eating disorders who present with comorbid diagnoses and a history of

chronic treatment failure require a more flexible, eclectic, and collaborative approach to treatment that includes individual and group psychotherapy; team consultation (Sansone, Fine, & Sansone, 1994); and a comprehensive focus on eating disorder symptoms, interpersonal skills, affect regulation, and impulse control (Zeeck et al., 2007).

Dialectical behavior therapy (DBT), a multidisciplinary treatment approach that was originally developed for clients with borderline personality disorder, is of particular interest given its effectiveness in reducing impulsive and self-destructive behaviors in a population once considered "treatment resistant" (Linehan, 1993a, 1993b). DBT is associated with significant reductions in suicidal and self-injurious behaviors, substance abuse, anger outbursts, treatment dropout, and frequency of hospital visits (Linehan, Armstrong, Suarez, Allmon, & Heard, 1991; Verheul et al., 2003). Given these findings, modified DBT approaches have been the focus of several treatment studies of eating disorders. There is evidence to support the use of DBT skills training (offered either individually or in a group format) for clients with less severe bulimia nervosa and binge eating disorder (Chen & Safer, 2010; Safer, Robinson, & Jo, 2010; Safer, Telch, & Agras, 2001; Telch, Agras, & Linehan, 2001).

Although these data are promising, our interest as clinicians and researchers has been in the development of treatments for complex, multidagnostic, difficult-to-treat individuals with eating disorders. As we discuss later in this article, such clients are characterized by repeated treatment failures, significant therapy-interfering behaviors, high rates of psychiatric comorbidity, and pervasive skill deficits that typically involve emotion regulation. The data for this population, however, are

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limited. Two case-series reports (Chen, Matthews, Allan, Kuo, & Linehan, 2008; Palmer et al., 2003) and two uncontrolled trials (Ben-Porath, Wisniewski, & Warren, 2009; Kröger et al., 2010) suggest that more intensive DBT protocols, modified to include specific content for eating disorders, may be more efficacious for clients with such a disorder and comorbid borderline personality disorder. Because of our interest in continuing to explore the integration of traditional, empirically supported treatments for eating disorders and the application of the full DBT model to them, we present a novel DBT program for complex and difficult-to-treat clients with eating disorders. First, we address the treatment conceptualization and briefly outline the inclusion/exclusion criteria for individuals who are admitted to the Multidiagnostic Eating Disorder (MED)-DBT program. Secondly, specific eating disorder and DBT treatment components and their application to complex, multidagnostic, difficult-to-treat clients are discussed. We highlight how the MED-DBT program differs from standard day treatment programs (DTPs) for eating disorders. Finally, examples of key DBT strategies (e.g., obtaining commitment, consultation with the client) are provided along with a brief discussion of clinical implications and future directions.

■ Treatment Model Conceptualization

On the basis of practice guidelines established by the American Psychiatric Association (2006) for the treatment of eating disorders, individuals with complex and MED presentations often meet criteria for higher levels of care (e.g., inpatient or residential programs) that focus primarily on weight restoration and nutritional stabilization. In contrast, the standard DBT model (Linehan, 1993a) is grounded on the premise that difficult-to-treat individuals with Axis II pathology, recurrent suicidal/self-injurious behavior, and pervasive therapy-interfering behaviors require a 1-year outpatient commitment. This 1-year commitment to once weekly individual and group therapy was designed to foster the building of a life worth living (i.e., eliminating destructive behaviors and actively pursuing a life beyond illness and overreliance on treatment settings) within the structure of an outpatient model (Linehan, 1993a).

As discussed previously, the literature suggests that treatment for this complex population might be strengthened by an approach that involves a synthesis of both eating disorder and DBT treatments (Ben-Porath et al., 2009; Chen et al., 2008; Kröger et al., 2010; Palmer et al., 2003). We are unaware of data that address or evaluate such a comprehensive treatment model specifically, but it has been our clinical experience that attending solely to eating disorder symptoms sometimes results in treatment being derailed by therapy-interfering behaviors, significant emotion dysregulation, and suicidal crises. Likewise, we have observed that providing DBT without targeting eating disorder symptoms may result in meaningful reductions in suicidal/self-injurious behaviors and/or therapy-interfering

behaviors but may fail to produce significant symptom reduction for the eating disorder, specifically among clients with anorexia nervosa or those whose eating disorders require higher levels of clinical care (Federici, 2009). The previously mentioned research recommendations and our own clinical experience indicate that the synthesis we describe in this article is the development of a model that incorporates a higher level of care, a focus on eating disorder treatment that is consistent with standard practice, and a substantial commitment to building a life worth living. The result has been the development and implementation of the MED-DBT program, an intensive outpatient intervention that includes standard eating disorder treatment components and standard DBT components.

■ Guidelines for Participation in the MED-DBT Program

Given that standard treatment programs for eating disorders have demonstrated empirical support, clients are required to have either (a) experienced repeated treatment failures from standard day treatment, residential, and/or inpatient settings or (b) participated in standard eating disorders programming for a minimum of 28 days without a decrease in symptoms. This 1-month criterion is based on data indicating that a failure to establish an upward weight-gaining trend (Hartmann, Wirth, & Zeeck, 2007) or a failure to decrease binge/purge behaviors in the first 4 weeks of treatment (Fairburn, Agras, Walsh, Wilson, & Stice, 2004) are associated with a high probability of being identified as a treatment nonresponder. In addition to meeting one of the above criteria, clients must also meet one or more of the following criteria:

1. Present as multidagnostic, as evidenced by an additional co-occurring Axis I disorder/s (e.g., major depressive disorder, posttraumatic stress disorder) and/or Axis II disorder/s (e.g., borderline personality disorder, obsessive compulsive personality disorder).
2. Struggle with pervasive emotion regulation deficits that commonly lead to symptoms, as evidenced by an inability to adaptively regulate, communicate, or tolerate affect.
3. Historically have been unable to generalize skills outside of standard treatment, as evidenced by relapse in symptoms posttreatment or during treatment.
4. Present with considerable therapy-interfering behavior(s) such that they cannot remain in standard treatment for eating disorders without significant adverse consequences to the therapy milieu (e.g., hostility or anger toward treatment providers or coclients, recurrent absences, frequent omission of symptoms).

Overarching Structure and Treatment Components

There is a need for a higher level of care for this multidagnostic and difficult-to-treat population. Unlike the standard DBT

outpatient model, the MED-DBT program is predominately a group-based model. The program includes an intensive outpatient program (IOP; 3 hours/day) and a DTP (6 hours/day). Determination of level of care is made collaboratively between the client and the treatment team and is based on symptom severity. Flexible program hours were chosen to allow clients time to attend classes, seek employment, and participate in volunteer placements in the spirit of developing an identity outside their eating disorder. Although the ultimate goal is to help clients move to the less intensive IOP hours as soon as possible, we have found that most clients need to start at a higher level of care (either DTP or 5-day IOP) and graduate to a lower level of care (e.g., DTP to IOP; 5-day IOP to 3-day IOP) as symptoms improve. As in standard DBT, all clients are required to attend weekly individual therapy with a DBT therapist. In addition, because of the ongoing nutritional, weight-related, and meal planning needs, clients are required to meet with the staff dietician on a weekly basis. Dieticians have been trained to adopt a DBT nonjudgmental stance (Linehan, 1993a) with clients (e.g., being nonjudgmental about slower progress or difficulties with the meal plan, freedom to choose rather than telling clients what to eat, greater collaboration and dialectical thinking with meal plans and exposure foods). Finally, clients are required to meet with the staff psychiatrist weekly for medical management. As described later in this article, clients are required to make a 6-month commitment to the program. Following is a description of the core treatment components.

Standard treatment components for eating disorders. Because of the importance of maintaining a concentrated focus on the eating disorder, the MED-DBT program includes the following empirically supported CBT treatment components (Garner, Vitousek, & Pike, 1997; Wilson et al., 1997; Wilson, Grilo, & Vitousek, 2007): meal planning and prescription of regular meals, structured meals and snacks, weekly weigh-ins, self-monitoring of food and body weight, psychoeducation pertaining to weight and eating, teaching self-control and problem-solving strategies to prevent behaviors, managing thoughts about eating disorders, and stimulus control. In our program, these treatment components are delivered by counselors, psychologists, and registered dieticians who are highly trained in the treatment of eating disorders and DBT. Because traditional treatment components for eating disorders have been discussed extensively in the literature (Zipfel et al., 2002), we do not describe them in this article except to emphasize that these components are essential and included in the MED-DBT program.

Standard DBT components. Consistent with the DBT model (Linehan 1993a, 1993b), the program is organized around the DBT treatment hierarchy, which, in order of priority, includes the following four targets: (a) reducing life-threatening behaviors (i.e., self-injurious behaviors, suicidal ideation, eating-disorder symptoms that are life-threatening), (b) reducing behaviors that interfere with the therapeutic

process (e.g., premature termination, missing therapy appointments), (c) reducing behaviors that interfere with the client's quality of life (e.g., unemployment, divorce, financial instability), and (d) increasing behavioral skill use (Linehan et al., 1991). (For a more detailed discussion of how these treatment components have been adapted for individuals with eating disorders, refer to Wisniewski & Ben-Porath [2005] and Wisniewski, Safer, & Chen [2007]).

Individual DBT therapy. As is true for clients in standard DBT, all clients in the MED-DBT program are assigned a primary DBT therapist with whom they meet weekly for individual therapy (50 minutes/week). Although most of the treatment is delivered within a group format, the individual therapist is viewed as an essential and core component of effective treatment. All therapists follow the DBT treatment hierarchy, as previously described, in all individual and group interactions with clients. Within that context, the individual therapist works collaboratively with the client to establish and make progress toward program and life goals, integrate learning that occurs in the groups, generalize skills, manage therapy-interfering behaviors, and consult with the client on how to interact effectively with other team members and medical providers (Linehan, 1993a). Therapists on a standard DBT team must have expertise in borderline personality disorder and the delivery of DBT; individual therapists on the MED-DBT team must also have additional competency in treating eating disorders.

DBT skills group. DBT skills training groups are a fundamental component of DBT and are designed to teach clients more adaptive ways to cope with painful emotions and difficult life circumstances. Standard DBT is taught in a didactic/classroom format, for 2.5 hours, once a week. In DBT skills groups, clients are taught mindfulness, interpersonal effectiveness, distress tolerance, and emotion regulation skills. To increase continuity and encourage skills generalization throughout the treatment week, the MED-DBT program provides two 1-hour sessions of skills training each week. Consistent with DBT, each group begins with a mindfulness activity, which is followed by homework review and a didactic presentation of new skills to be learned. Finally, sessions are conducted to focus on homework setting, problem-solving obstacles to skills use, and homework completion.

Telephone skills coaching. Individual therapists offer after-hours contact with their clients via telephone with the primary aim of preventing suicidal/self-injurious behaviors or life-threatening eating disorder symptoms. As in standard DBT, clients are instructed to call on the ascending arm of the crisis, before they are actively suicidal, thereby reinforcing clients for asking for help appropriately rather than for being in a crisis. In the MED-DBT program, telephone skills coaching has been expanded to also include non-life-threatening eating disorder behaviors. Thus, clients are instructed to call when they need assistance in resisting urges to engage in eating disorder behaviors. Data from our clinic indicate that the most

common reason for calling (i.e., 37% of calls) was to resist eating-disorder-related urges. After-hours calls were generally brief, succinct, and skill focused. Data derived from our clinic indicate that the average length of time spent per call was $M = 5.97$ minutes ($SD = 4.66$) (Limbrunner, Ben-Porath, & Wisniewski, 2011). For a more detailed discussion of the adapted DBT telephone coaching protocol for individuals with eating disorders, please refer to Wisniewski and Ben-Porath (2005).

DBT team consultation. All DBT individual therapists and MED-DBT group leaders are required to attend a weekly 90-minute consultation team meeting to strengthen their adherence to the model and to reduce staff burnout. Regarded as an integral treatment component in DBT, the consultation team is conducted strictly as therapy for the therapists and is not designed to be a clinical rounds meeting. (*Note.* Case staffing takes place in a separate 60-minute weekly meeting.) For our consultation team, each meeting begins with a mindfulness activity and agenda setting, the latter of which is guided by the treatment hierarchy (i.e., life-threatening behaviors take priority, followed by behaviors that interfere with therapy and quality of life).

Additional and Unique Program Content

As we discussed previously, there are a number of standard eating disorder and DBT treatment interventions in the MED-DBT program. In addition to those described earlier (e.g., the adapted DBT skills group), we conduct a daily goal-setting group. Traditional DBT diary cards that track suicidal and self-injurious behaviors have been adapted to include food diaries and eating disorder behaviors (Wisniewski, Safer, & Chen, 2007) and are reviewed daily during the goal-setting group. In addition, each week, clients work with group leaders and coclients in the behavior chain analysis group to identify key thoughts, emotions, and discrete actions that led to a targeted behavior. The group also works together to identify concrete strategies or solutions to help eliminate the behavior in the future. Our life-worth-living group uses a variety of activities (e.g., scrapbooking, group discussions, presentations) to help clients identify and generalize personal values, dreams, and life goals that encourage the development of a life outside of their illness. The highly creative and distinctive DBT-in-action group was added to help clients explore key DBT concepts and metaphors using a collection of expressive art activities (e.g., expressing emotion with color and drawing, creating personalized distress tolerance boxes, drawing or using collages to express “states of mind”). Finally, in DBT 101, group leaders choose relevant topics pertaining to DBT to review and discuss with the group (e.g., rationale for contingency management, effective use of telephone skills coaching, the biosocial theory). Not only does this group help to dispel misconceptions about treatment, but we have found that collaboration regarding treatment goals increases because education and treatment rationales are continually presented.

The energy surrounding the MED-DBT program elicits enthusiasm from clients and staff alike. There is a pervasive awareness at our center that the treatment is special and unique. All DBT team members (including nutritionists and psychiatrists) subscribe to the theory, model, and assumptions of DBT (e.g., clients are doing the best they can; clients want to improve; clients need to do better, try harder, and be more motivated to change; clients cannot fail in therapy; Linehan, 1993a). The result is an environment that is infused with DBT language, pervasive skill use, and active modeling by staff of adaptive and skillful behavior. Group rooms are filled with distress tolerance items, posters that outline various DBT skill sets, and ideas for mindful living. One of the features our clients report being particularly fond of is that staff members are expected to follow the same guidelines and contingencies regarding eating, attendance, and management of emotion as the clients. For example, a staff member who does not finish his or her meal or snack in the time allotted is expected to drink a meal supplement on the spot (just as the clients are expected to do). Not only does this enhance the client’s sense of trust, but it helps to teach clients that we are all human, all doing the best we can, and that we all need to work harder. As clients move through treatment and gain greater skill development, they are encouraged to take on more active roles within the program (e.g., leading mindfulness activities, teaching a portion of a skill, leading a behavior chain group).

With all team members working within the DBT framework, the DBT culture is impossible to miss. Regardless of the group or individual DBT team member with whom a client is in contact, he or she can expect to be treated with a dialectical and nonjudgmental stance, consultation-to-the-client responses, and assistance with DBT skill development and generalization. For example, one of our clients returned to the group room with a smile on her face after her weekly meeting with the staff psychiatrist. When asked how the meeting went, she pulled out the medical prescription given to her by the doctor, which read “Practice wise mind three times per day as prescribed, try radical acceptance once upon waking, and use distress tolerance skills as needed.” The importance of the DBT culture cannot be understated. It communicates confidence in the program, camaraderie among staff and between clients and therapists, and a sense that clients are participating in something special and exciting.

Use of Specific DBT Strategies in the MED-DBT Treatment Milieu

Thus far, we have described the specific treatment components of the MED-DBT program (e.g., the “what” of the program). In the following section, we highlight key stylistic strategies that are germane to the successful implementation of the treatment (e.g., the “how” of the program).

Orientation and Commitment

The need to explicitly address motivational issues is of particular importance for clients with eating disorders (Tantillo, Bitter, & Adams, 2001; Vitousek, Watson, & Wilson, 1998). Motivation for change and pretreatment change expectancies are significantly related to treatment outcome across a range of diagnostic categories (Prochaska, DiClemente, & Norcross, 1992). Clients who do not expect to improve in treatment, disagree with the therapy rationale, or do not believe in their own capacity for change are significantly less likely to succeed in treatment (Westra, Dozois, & Marcus, 2007). One of the key components of DBT that is considered to contribute to successful outcome is the inclusion and flexible use of commitment strategies (Ben-Porath, 2004; Bornovalova & Daughters, 2007; Lynch, Chapman, Rosenthal, Kuo, & Linehan, 2006). Commitment strategies in DBT refer to an explicit set of strategies (e.g., devil's advocate, foot-in-the-door, freedom to choose in the absence of alternative, cheerleading, linking to prior commitments) used by the therapist to reduce ambivalence, strengthen internal motivation, and increase client commitment to treatment and life goals (Linehan, 1993a). Commitment strategies are applied throughout the treatment program, not solely during the pretreatment phase. Although research is lacking on the specific use of these particular DBT strategies, there is speculation that the early focus and sustained emphasis on building commitment is an essential component of treatment and a potential catalyst for change. Some investigators have suggested that these particular DBT strategies increase client commitment to treatment and strengthen the therapeutic alliance (Ben-Porath, 2004; Sneed, Balestri, & Belfi, 2003).

Participation in the MED-DBT program requires a substantial commitment to treatment. Clients attend an average of four pretreatment sessions with their individual DBT therapist to determine whether the MED-DBT program is an appropriate fit, motivation to treatment and life goals are sufficient and genuine, and the client and therapist agree to enter a longer term treatment contract together. The client is expected to make a strong commitment to the following treatment goals: (a) staying alive, (b) eliminating symptoms of eating disorders, and (c) attending the program for a 6-month period. The 6-month commitment is based on empirical data (Bohus et al., 2004; Chen et al., 2008), which suggest that shorter durations (e.g., 3–12 months) of DBT may be sufficient to establish therapeutic change. When a client and his or her therapist agree that the MED-DBT program is a good fit, one or two orientation sessions are scheduled with a member of the MED-DBT treatment team to provide a more detailed orientation to the program.

Dialectics and Collaboration

Fundamental to standard DBT is the notion of dialectics—that multiple truths can exist in a given moment, in contrast to the notion that one idea or belief is more valid, true, or right than another (Linehan, 1993a). From a dialectical perspective, the

resolution of tension is not to have one party override another; instead, resolution is achieved by decreasing polarization and searching for a synthesis between two seemingly opposite points of view (Linehan, 1993a). The application of a dialectical stance is not a characteristic feature of traditional approaches to treating eating disorders. For example, standard intensive programs for treating eating disorders generally adhere to specific expectations regarding rates of weight gain (typically 2–3 pounds per week), meal plan compliance, and overall behavioral progress during treatment, with less emphasis on negotiation and individualized planning (Dancyger, Fornari, & Katz, 2009; Halmi, 2006). However, more positive clinical outcomes, including greater treatment retention and fewer episodes of self-injurious behavior, have been associated with approaches that emphasize greater choice, collaboration, and autonomy (Geller, Brown, Zaitsoff, Goodrich, & Hastings, 2003; Vandereycken & Vansteenkiste, 2009) and those in which therapists are rated as practicing a dialectical stance (Shearin & Linehan, 1992). Thus, it is possible that a less controlling and more collaborative therapeutic stance may be a more effective treatment approach for the multidisordered individuals with eating disorders who have experienced previous treatment failures while in more controlled and uniform environments.

The MED-DBT program is infused with a dialectical and non-judgmental worldview. All therapists in the MED-DBT program continually strive to balance acceptance and change, flexibility and stability, nurturance and challenge, and a focus on deficits with a focus on capabilities (Linehan, 1993a). For example, a DBT therapist might work with a client to find a synthesis between what the client wants (e.g., to remain underweight) and what the treatment team wants (e.g., weight gain to a healthy body mass index). Rather than getting stuck (or polarized) in a power struggle, the client and therapist work together to acknowledge the validity of both positions in the spirit of finding common ground (e.g., slower weekly weight gain than the treatment team wants but a faster rate of gain than the client wants).

Client: I don't care; I'm not gaining any more weight. I will lose my mind!

Therapist: I totally hear that you are so afraid of what you will feel like if you gain more weight right now (acceptance/validation) and yet we're kind of stuck because your heart rate is still really low, which tells me you aren't at a healthy enough weight and the team wants to see you gain more weight this week (dialectical stance/push for change). How can we manage this? (consultation to the client) What are you willing to do this week? (solution generation)

Client: I don't know . . . this feels awful!

Therapist: It looks really uncomfortable for you. (validation) What do you think would be a good synthesis here? (problem solving)

Client: I guess I can try to meet the 1 pound for this week and see how I feel.



Therapist: Wow. That is so willing. Let's figure out what skills will help you through this. (reinforcement, problem solving)

This framework is especially useful when working with clients who have an eating disorder who are ambivalent about change or those who demonstrate perfectionist, rigid, and/or highly critical thinking styles. The process of finding a synthesis between opposing views (as opposed to determining right vs. wrong) serves to decrease polarization and increase collaboration.

Consultation to the Client

One of the distinctive and dominant features of standard DBT is the emphasis on helping clients act as their own agents rather than having treatment providers act on behalf of the client. Linehan (1993a) stated that the purpose of this approach is to teach clients to take responsibility for their own lives, decrease miscommunication and disagreements among health care providers and significant others, and promote respect for the client. At the core of this approach is the view that complex, multidagnostic clients with eating disorders are capable of acting on their own behalf (or of learning the skills to do so). In the MED-DBT program, the consultation-to-the-client approach means that team members do not rush to solve problems for their clients; rather, they act as consultants with the aim of facilitating the client's own skillful interaction with the environment. According to Linehan (1993a), this approach is typically quite different from traditional health care settings in which multidagnostic or difficult-to-treat clients receive care, where health care providers may spend a significant amount of time coordinating appointments, treatment needs, and family meetings for the client. Examples from our program include having clients coordinate their own appointments for individual therapy and with physicians, nutritionists, and other treatment specialists; expecting clients to be responsible for obtaining lab and EKG results in a timely fashion; and coaching clients to be interpersonally effective in their discussions with other health care providers. For example, a client returned to the group after her weekly nutrition meeting looking and acting very angry (e.g., frowning, slamming her binder on the table). The client reported feeling angry at the nutritionist for not reducing her weight range and adding more food to her meal plan. She demanded that the group leaders "take the issue to team to discuss" because she "had enough with the nutritionist and won't see her anymore. She doesn't understand what I need." More traditional settings might discuss the client's anger and disagreement with the nutritionist's recommendations at the next staff meeting, or perhaps the group leader would speak to the nutritionist later in the day to determine how to help the client with her meal plan. In the MED-DBT program, however, the client would be coached to manage the situation for herself using DBT interpersonal effectiveness skills. In the following

exchange, the DBT therapist suggests that the client use a DEAR MAN script (**D**escribe the situation, **E**xpress emotion using "I" statements, **A**ssert your need, **R**einforce the other, **M**indfulness of your goal, **A**ppear confident, **N**egotiate).

Therapist: Oh man, no wonder you feel so angry. I know how much you hate getting a meal plan increase and hate feeling like people don't get you (validation). Hmm, you still need to meet with the nutritionist each week (dialectical stance/observing program limits). How are you going to manage getting your needs met with the dietician? (consultation to the client)

Client: I'm not! You can do it. Tell her that I don't agree with her weight range and I'm not following this new meal plan.

Therapist: Me!?! Are you kidding? You know I am not going to solve your problems for you (*said irreverently with a smile*). I do, however, really want to help you get your needs met because you are really looking and sounding so upset." (validation). Have you told the nutritionist how you feel after your sessions? (consultation to the client)

Client: No. She only cares about one thing—making me gain weight!

Therapist: That must be really hard to go into a session like that and feel like the other person only hears one side. (validation) Not sure what you think (collaborative), but my experience is that telling the other person what I need more clearly usually helps me get closer to what I want. (self-disclosure, modeling skill use) Would you consider writing out a DEAR MAN script before your next session with the nutritionist and maybe you and I can role play what you might say to her? (consultation to the client)

Client: I guess. I'm not sure it will help, but I'll try.

Therapist: Fabulous! Really looking forward to seeing it (reinforcement). In the meantime, do you need some help thinking through what skills will help you tolerate the meal plan increase?

The successful application of this approach requires that clients are well oriented to the rationale for its use; initially, many of our clients are not accustomed to taking greater responsibility for their lives. We have found, however, that this approach facilitates greater self-confidence, overall skill use, and feelings of empowerment among clients.

Contingency Management

A key difference between our program and standard approaches to treating eating disorders is the ongoing use of contingency management strategies (Linehan, 1993a), which are a set of techniques designed to enhance adaptive behavior (e.g., the use of therapist warmth, approval, positive reinforcement) and extinguish maladaptive behavior (e.g.,

withdrawal of warmth, overcorrection protocols). Together with their individual therapists, clients in the MED-DBT program are expected to set collaborative goals with corresponding positive and negative contingencies. This often involves an explanation of how the principles of operant and classical conditioning work and helping clients to identify for themselves the kinds of contingencies they can use to change their own behavior. For example, one client attempted to target restrictive behavior after accepting that she chronically missed entire meals. She set a goal to eat a minimum of three meals each day and was willing to drink a nutritional supplement (e.g., Boost, Ensure) the next day in treatment if she did not meet this goal. She considered using positive reinforcement in the form of treating herself to a manicure if she was able to follow this plan for 5 days but decided that the incentive was not strong enough (she found herself thinking “Forget it, I’ll just restrict now and I can paint my own nails later”). Instead, she realized that the avoidance of a nutritional supplement would decrease the behavior of restriction more effectively (e.g., “I really don’t want to have to drink that supplement tomorrow; I had better follow my meal plan”). This plan worked to greatly reduce her habit of missing entire meals.

There are also a number of program-specific contingencies that clients (and staff) are expected to follow. They are in place either to help shape maladaptive behaviors (e.g., tardiness) or encourage more adaptive ones. For example, both clients and staff who arrive late to programming must overcorrect by coming to the center 1 hour before the start of programming (offered 1 day per week only from 7 a.m. to 8 a.m.); during this time, they complete a detailed behavior chain and solution analysis of their late behavior. Likewise, aversive contingencies are used when clients attend the daily goal-setting group with incomplete diary cards (“Oh, this isn’t done. You’ll need to take time out of your goal setting now to complete it.”). It is absolutely essential for these strategies to be applied consistently and in a nonjudgmental manner and for clients to be fully aware of the rationale for their use; otherwise, clients tend to view them as punitive and unsympathetic. Clients sometimes find that they set goals and contingencies that they later discover they no longer want to honor. It is program policy that the clients honor the written contingency until they are able to meet with their therapist to discuss changing the contingency to one that feels more appropriate. If clients choose not to honor the contingency in the moment, they are asked to leave the program until they meet with their therapist for further discussion.

Summary and Future Directions

The aim of this article was to describe the rationale, program components, and unique characteristics of an innovative DBT program for multidagnostic clients who also have eating disorders. Given the complex and unique treatment needs of this population, a model that uses traditional treatment compo-

nents for eating disorders and level of care recommendations along with the full DBT model is a promising and potentially valuable approach. Several important clinical implications and treatment limitations are noted. As mentioned earlier, in the MED-DBT program, therapists are not only well versed in the provision of DBT but in the treatment of eating disorders. Application of this particular program may not be feasible for clinicians or treatment teams who do not have the requisite training or those who are not available to provide ongoing telephone consultation. Furthermore, the MED-DBT program is designed to function within the context of a multidisciplinary treatment team that includes psychiatry and nutrition. Without further treatment development and empirical support, this particular model would not be recommended for clinicians working independently (e.g., those in stand-alone private practice). Finally, it is important to note that the empirical data referred to in this article on the use of DBT and regarding eating disorder treatment strategies are based largely on data involving female participants; thus, generalization to other populations (e.g., males, transgender, individuals from varying cultural/ethnic backgrounds) is limited.

Currently implemented at a specialized treatment center for individuals with eating disorders, the MED-DBT program is being evaluated for its impact on reducing symptoms of these disorders, suicidal and self-injurious behaviors, therapy-interfering behaviors, and frequency of hospitalization visits. As with the development of any new program, thorough analyses of feasibility and acceptability are under way. If the MED-DBT program is found to have significant benefits, these findings would have far-reaching and cost-effective implications (e.g., need for less frequent and extensive psychiatric services, improved quality of life, possible reduction of staff burnout) for the treatment of this complex and underserved population.

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