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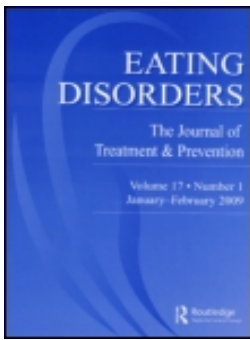
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The Integration of Family-Based Treatment and Dialectical Behavior Therapy for Adolescent Bulimia Nervosa: Philosophical and Practical Considerations

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Dialectical behavior therapy (DBT) and family-based treatment (FBT) are two evidence-based interventions that have been applied in the treatment of bulimia nervosa (BN) in adolescents. While DBT focuses on providing skills for coping with emotion dysregulation that often co-occurs with BN, FBT targets the normalization of eating patterns. The purpose of the current article is to introduce an integration of both treatments to provide a more comprehensive approach that targets the full scope of the disorder. We provide a review of the conceptual similarities and differences between FBT-BN and DBT along with strategies to guide a blended treatment approach. Given the strengths and limitations of either independent treatment, DBT and FBT-BN complement one another and together can address the range of symptoms and behaviors typically seen in adolescent BN.

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To date, adolescent bulimia nervosa (BN) has received markedly less empirical attention than adolescent anorexia nervosa, with only two controlled trials demonstrating modest rates of full symptom remission (Le Grange, Crosby, Rathouz, & Leventhal, 2007; Schmidt et al., 2007). Le Grange et al. (2007) found that family-based treatment for adolescent BN (FBT-BN) was more efficacious than supportive psychotherapy, while Schmidt et al. (2007) found that cognitive behavioral therapy (CBT) guided self-care resulted in slightly more rapid reduction of bingeing than family therapy. In essence, BN is a disorder of complex etiology, characterized by frequent episodes of binge eating and purging/compensatory behaviors, which affects approximately 1–3% of the American population (Hudson, Hiripi, Pope, & Kessler, 2007; Swanson, Crow, Le Grange, Swendsen, & Merikangas, 2011). Furthermore, alongside core binge/purge-type symptomatology, frequent comorbid complexities include medical and psychological disorders, and impaired psychosocial functioning (Wonderlich & Mitchell, 1997), which may run over a protracted and relapsing illness course (Steinhausen, 2002). In addition to bulimic symptoms, 40% of adolescents with eating disorders report self-harming, which co-occurs significantly with bingeing/purging (Crow, Swanson, Le Grange, Feig, & Merikangas, 2014; Peebles, Wilson, & Lock, 2011). Population-based samples illustrate that among adolescents with BN, 53% reported SI, 26% reported a current plan for suicide, 35% reported a previous suicide attempt, and 17% reported multiple suicide attempts (Crow et al., 2014). It is important to note that participants for the two controlled studies (Le Grange et al., 2007; Schmidt et al., 2007) were excluded for having acute suicidality, substance dependence, or psychosis, therefore limiting the conclusions that we are able to draw from the existing evidence base about patients with a more complex diagnostic presentation.

More recently, it has been demonstrated that BN symptoms among adults, at least in part, are a means of coping with dysphoric mood states and interpersonal stress (Lavender et al., 2014), which consequently, may be recursively reinforced by environmental factors. In addition, a growing consensus suggests that neurobiological vulnerabilities contribute significantly to the pathogenesis of BN (Kaye, 2008; Kaye & Bailer, 2011), suggesting intrapsychic, interpersonal, and neurobiological factors are all salient in presentations of BN. As such, clinical treatments must consider (a) the core behavioral symptom profile of BN, (b) the neurobiological correlates of binge/purge and other impulsive behaviors, and (c) the dysregulated mood states which precipitate and maintain them.

Indeed, treatments mobilizing family members to directly intervene into symptomatic BN behaviors, such as FBT (Le Grange & Lock, 2007), may help override neurobiological vulnerabilities and the ego-syntonic components of BN by installing a framework that protects the symptomatic adolescent from decision-making capacities. Alternatively, dialectical behavior therapy (DBT) centrally focuses on skill development in regulating the intensely

experienced affective states characteristic of BN (Linehan, 1993; Safer, Telch, & Chen, 2009), which is thought to mitigate the biologically-driven vulnerability towards emotional dysregulation and vulnerability to negative affect (Smyth et al., 2007) and self-destructive behaviors (Telch, 1997). Preliminary evidence for using DBT with BN in adults (Bankoff, Karpel, Forbes, & Pantalone, 2012) and in adolescents (Fischer & Peterson, 2015; Salbach-Andrae, Bohnkamp, Pfeiffer, Lehmkuhl, & Miller, 2008) has been promising. However, keeping in mind that DBT does not fully articulate a role for the family in assisting with recovery, and similarly that FBT-BN's primary focus is on regular eating and not emotional regulation, integration of these two treatments may be warranted to comprehensively encapsulate the full scope of deficits experienced by those adolescents with BN.

PHILOSOPHICAL SIMILARITIES

Non-Judgmental Stance

FBT-BN posits that adolescents with a bulimic disorder are not unwell of their own volition, but rather are experiencing a partially ego-syntonic illness whose behavioral symptoms are largely driven towards offsetting the intense anxiety brought about by the illness itself (Le Grange & Lock, 2007). As such, FBT-BN adopts a non-judgmental stance to both parents and adolescents alike throughout treatment. Similarly, DBT assumes that, in the context of emotional dysregulation, the patient and the family members aim to cope as skillfully as possible despite powerfully experienced emotions, and a non-pejorative/non-blaming stance is adopted with family members and adolescents. Furthermore, both FBT-BN and DBT posit that high expressed emotion and parental criticism may help exacerbate symptom severity and undermine treatment (Hoste, Lebow, & Le Grange, 2015), and both FBT-BN and DBT clinicians continually work to shape the language of the teen and parents towards non-judgmental neutrality.

Separating the Adolescent From the Illness

In FBT-BN, the adolescent is not seen as being in control of their own behavior/manipulation; rather, the eating disorder is seen as controlling the adolescent (Le Grange & Lock, 2007). While this distinction is not explicitly made in DBT, this approach does encourage separation between the patient and the illness by helping the adolescent create an identity outside of the illness (Linehan, 1993).

Behavioral Treatment Approach

In FBT-BN, the therapist focuses exclusively on re-establishing healthy eating for the adolescent and disrupting the behavioral features of BN (Le Grange

& Lock, 2007). This is central to FBT-BN, and a review of the adolescent's binge/purge log takes place at the outset of every family meeting, allowing the family to target the most symptomatic behaviors. DBT adopts a similar focus on behavioral change, targeting multiple problem behaviors that serve as attempts to regulate emotion. Adolescents complete diary cards to record emotions, urges, and behaviors, as well as the skills that were used throughout each week, and this diary card is used to set the agenda for each session (Miller, Rathus, & Linehan, 2007). Behaviors are targeted in order of priority, such that life-threatening behaviors are addressed first and foremost, followed by therapy interfering behaviors, and then quality of life behaviors.

Focus on Validation

Validation is considered a key strategy in FBT-BN, and parents are taught to support and comfort their child, while the therapist takes a stance of consistently and resolutely holding the parents and their family in positive regard (Le Grange, 2010). In addition, parental expressed emotion, critical comments in particular, toward adolescents correlate negatively with treatment outcome (Hoste et al., 2015), and as such, are immediately modified in FBT (Le Grange & Lock, 2007). DBT places a similar emphasis on validation at the forefront of all DBT interventions by encouraging therapists to maintain a delicate balance between validation of a patient's emotional experience while simultaneously activating change (Linehan, 1993).

PHILOSOPHICAL DIFFERENCES

FBT-BN and DBT share many commonalities, but there are certain aspects of the treatment approaches that appear somewhat incompatible. In this section these differences are explored and reconciled.

Etiology and Functionality of Behavior

In keeping with the largely unsubstantiated etiological origin of BN, FBT-BN adopts an agnostic stance to etiology, which assists in absolving parents and adolescents of any potential self-blame around "causing" the illness, which in turn assists in mobilizing the family into an active role throughout treatment (Le Grange & Lock, 2007). However, DBT is predicated on the biosocial model, which postulates that a child with a more emotional temperament may display stronger emotions, which when coupled with an invalidating environment, may result in the more pronounced expression of affective dysregulation (Linehan, 1993). While parents and adolescents are not blamed for this pattern, the dynamic is pointed out to family members so that all

involved may work towards shifting this dynamic. Despite differing accounts as to the origin of symptom development, both FBT-BN and DBT remain focused on behavioral symptom expression, which in turn offer concrete goals for treatment to target.

Family Involvement

In FBT-BN, the family is central and pivotal in the process of treatment, especially at the outset. This is due not only to the adolescent being embedded in their family of origin, but also because while ill with BN, the adolescent is seen as being unable to make healthy decisions about eating and related behaviors (Le Grange & Lock, 2007). In contrast, DBT was developed in the context of adult disorders of emotion regulation. As such, the focus of treatment has traditionally been on intervening at the individual level, and on coaching the adult patients themselves on how to intervene in their own environment. However, in the context of adolescence, and particularly when the environment is intransigent and powerful, the family can be included as needed when the patient may not effectively intervene on their own behalf (Linehan, 1993). In a combined approach, the family is involved more centrally, as in FBT-BN, although this can be adjusted according to the capacity and motivation level of the adolescent. For example, parents would be asked to remove objects used in life-threatening target behaviors (e.g., self-harm implements) and would be encouraged to have a contract with the adolescent that would specify behavioral contingencies. Dialectically at the same time, the adolescent would be empowered to act more skillfully, and the parents would be charged with being receptive and validating of the increased skillful behavior.

Mechanisms of Change

In delineating the mechanism of symptom remission, it may appear that FBT-BN and DBT operate via differential pathways of symptom remission. FBT-BN posits that the adolescent's ambivalence about their symptomatic behaviors, coupled with the neurobiological vulnerabilities characteristic of eating disorders, grossly impede the adolescent's ability to make healthy decisions (Murray & Le Grange, 2014). As such, a strong interventive parental framework is required in counteracting all pro-BN behaviors, insulating adolescents from further symptom escalation (Le Grange & Lock, 2007).

In DBT, it is assumed that symptomatic behaviors arise out of dysregulated attempts to cope with intense emotional states, and thus primarily seeks to assist the adolescent in regulating their own affective states. The reported mechanisms of change in FBT-BN and DBT, while different, are not mutually exclusive, and synthesizing the active mechanisms of change

in both treatments is possible. This integration may seek a flexible blend of direct parental intervention into pro-BN and life threatening behavior, while assisting adolescents in their own management of intense affective states that result in symptomatic behaviors. However, in determining the delicate balance of parental- versus adolescent-driven symptom remission, it is critically important to frequently assess (a) the severity of symptoms, (b) the adolescent's ability to intervene in their own environment (c) the transiency of the family, and (d) adolescent willingness/motivation to learn and apply skills.

Confidentiality

In FBT-BN, given the largely conjoint nature of family meetings, little confidentiality is offered to adolescents around what is reported back to parents, and all symptomatic behaviors are necessarily shared with parents to allow for interventive measures. However, DBT typically adopts a firmer stance around adolescent confidentiality, allowing adolescents more scope to decide for themselves whether to report certain behaviors (Miller et al., 2007). For instance, while life-threatening behaviors are reported to parents, symptomatic behaviors are not typically reported by the therapist to the parents, as this may limit adolescent disclosure of behavioral symptoms. In a combined approach, a frank and open discussion upon commencing treatment around which behaviors ought to be reported to parents in order to ensure adolescent safety and target symptom remission may serve well in establishing the bounds of confidentiality. While keeping in mind that parents require feedback to gauge the efficacy of their assistance/interventions, and that adolescents may also benefit from developmentally appropriate autonomy in some areas, it can be beneficial for each family to discuss the risk of specific adolescent behaviors, and collaboratively determine which behaviors warrant a breach of confidentiality and parental assistance.

Prescription

FBT-BN is typically non-prescriptive in that therapists encourage parents to rely on their own judgment in how best to assist their child, asserting only that symptoms need to be swiftly interrupted by any means necessary. On the other hand, DBT is quite prescriptive, often incorporating individual skill use and aspects of behavioral parent training in a didactic manner. In a combined approach, interventions are developed collaboratively, with the therapist taking a more prescriptive role in the context of behaviors that may be inadvertently reinforced. For instance, the DBT therapist would point out that parental efforts to reduce distress may inadvertently reinforce symptoms in some instances, and solicit the family's feedback on how to disrupt that cycle.

STRATEGIES TO INCLUDE IN A BLENDED APPROACH

FBT-BN and DBT appear to be philosophically compatible, and offer several complementary strategies that are likely to be useful in treating multidagnostic BN adolescents. The approaches might be integrated at every level of care for eating disorders, but this section outlines strategies that could be incorporated in most treatment settings.

Family Diary Card Review

Both FBT-BN and DBT sessions typically commence with a review of symptomatic behaviors. In an integrated approach, the diary card includes a record of all target behaviors from the preceding week, and may typically include dietary restriction, binge-purge frequency, self-harm, and impulsive behaviors. Parents are encouraged to discuss whether their observations of behaviors match adolescent reports, and family sessions are structured according to the behaviors disclosed on the diary card.

Family Behavior Chain Analysis

In DBT, behavior chains are typically used to elicit the sequential steps preceding engagement in targeted behaviors, paying particular attention to outlining emotions, thoughts, and actions (Linehan, 1993). In FBT, family-wide sequential analyses are often conducted with a view to identifying helpful and unhelpful family interactions that may impact target outcomes (Murray, Wallis, & Rhodes, 2012). In an integrated approach, family-wide analyses may be used to identify the emotions, thoughts, and actions underpinning engagement in target behaviors, allowing for the development of co-constructed alternate points of intervention.

Family Crisis Plan

Patients in DBT typically develop a crisis plan to use when managing intense urges for impulsive behavior (Linehan, 1993). In integrating the development of this plan into a family-wide context for target behaviors, family members are explicitly involved in each step of the crisis plan. Central parental involvement in this plan allows for a greater degree of accessibility of support for adolescents, and may provide additional emotional support, validation, and distraction when needed for the adolescent. For instance, when managing acute and intense urges to binge or purge, crisis management plans may encourage adolescents to turn towards parents in assisting with emotional validation and distraction until urges subside.

Multifamily Skills Training

Teaching emotion regulation skills in a group format that included adolescents and caregivers would seem consistent with both FBT-BN and DBT. Given how disruptive an eating disorder is to a family's overall emotional and interpersonal functioning, teaching skills to the family can help regulate the emotions that arise in response to the restoration of normal eating, and those emotions that might be contributing to behaviors. Additionally these skills can help the parents regulate their own emotions in response to extremely difficult task of helping their child eat normally and reach Phase III of FBT-BN.

Interpersonal Effectiveness Strategies

In DBT, a number of strategies for interacting with people more effectively are taught to adolescents (Rathus & Miller, 2015). In the context of FBT-BN, using skills can be helpful, particularly around mealtimes when distress may be most elevated, for both adolescents and family members. Thus, co-constructed strategies for effective interpersonal communication may assist parents in effectively intervening into symptomatic behaviors, and may also help adolescents in accurately conveying to parents how help is required.

Telephone Consultation

Phone coaching to assist in the management of acute emotional crises is a central feature of DBT, and has been adapted for use with eating disorder patients (Wisniewski & Ben-Porath, 2005). Additionally with an integrated approach, the option of phone coaching is extended to parents, who may call the therapist for assistance in the management of acute emotional crises. This approach further centralizes and empowers the parents, which is consistent with FBT-BN, while ensuring that adolescents are able to access swift crisis management support, which is consistent with DBT.

Parent Training and Contracts

A common occurrence among families in adapting to the presence of an eating disorder is a reduced range of family interactions, with family life becoming gradually reorganized around mitigating the eating disorder-induced anxiety in the afflicted individual (Eisler, 2005). As a result, parental boundaries may become less firm, as parents often forego calling attention to ordinary boundary violations in favor of maintaining focus on the extraordinary circumstances around the eating disorder. From a behavioral learning perspective, any reduction in natural consequences of problematic behavior, may serve to inadvertently reinforce the target problematic behavior. As such,

behavioral contracts have been adopted for use in an integrated approach to BN treatment, in balancing the focus on rapid symptom remission with the potential ecological maintaining variables.

CONCLUSION

FBT-BN and DBT represent two distinct clinical approaches to the treatment of adolescent BN, and may share common theoretical assumptions. While integrating these two approaches presents some philosophical incongruence, their practical integration may offer significant advances in current treatments of adolescent BN, offering a dual therapeutic focus on swift behavioral symptom remission and underlying emotional states of both the adolescent and the family. We have outlined a series of theoretical similarities and discrepancies, and further documented a range of clinical strategies that may be utilized in an integrated approach. Although FBT-BN and DBT have accumulated an impressive amount of evidence for the treatment of adolescent eating disorders and emotion dysregulation respectively, this conceptual review articulates how these treatment strategies may be integrated in treating adolescent BN. Controlled empirical research is needed in supporting the theoretical framework described in the present article. Pending further empirical support in more controlled trials, more detailed pragmatic guidelines may better assist in the dissemination and clinical application of this integrated treatment model. To date, preliminary evidence demonstrates promising clinical outcomes (Murray et al., 2015), although more controlled long-term assessment is required.

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