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The MED-DBT Program
Development and Foundations

Eating disorders (EDs) are serious, multisystem illnesses characterized by persistent disturbances in eating behaviors, thoughts, sensory and perceptual experiences, and emotions that impact feeding behaviors, weight, and body image (Attia & Walsh, 2025; Brizzi et al., 2023; American Psychiatric Association, 2013). To live with an ED is to experience a range of very difficult and ongoing physical and psychological symptoms that are commonly minimized or misunderstood by those untrained and unfamiliar with them (Kazdin et al., 2017; Treasure et al., 2020; Tse et al., 2022). Effective and accessible treatment is of paramount importance given that EDs are associated with elevated mortality risk, physical health complications, and widespread psychological distress and impairment; they can severely decrease quality of life (Arcelus et al., 2011; Mitchison & Hay, 2014).

At the time of this writing, the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5-TR; American Psychiatric Association, 2022) identifies seven distinct EDs: anorexia nervosa (AN), bulimia nervosa (BN), binge-eating disorder (BED), avoidant–restrictive food intake disorder (ARFID), rumination syndrome, pica, and other specified feeding/eating disorder (OSFED). Though unique in some ways, each of the seven defined EDs shares three key features:

1. They are all characterized by the inability to adequately feed oneself (whether due to fears of the body changing, sensory difficulties, fears of aversive consequences, or problems with appetite-regulating hormones).
2. They are rooted in biological and neurometabolic processes (and not socially constructed illnesses, choices, or dieting fads).

3. They are associated with unique and pervasive psychological features (e.g., anxiety, emotional regulation difficulties, perfectionism) that distinguish them from disordered eating.

Definitions and diagnosis of EDs continue to evolve alongside new research findings. It is important for those in the field to stay current with respect to challenges and concerns with the diagnostic criteria—for example, use of BMI (body mass index) to differentiate between AN and BN; use of the term "atypical" anorexia; or controversy over whether ARFID does or does not involve body image disturbance (Thomas et al., 2023; Herpertz-Dahlmann, 2021; Sharpe, 2024).

Traditional/Frontline ED Treatments: A Brief Overview

EDs have long posed significant challenges in the fields of psychiatry and psychology. Historically, the treatment of EDs was often inconsistent and rudimentary, largely because these conditions were poorly understood. In the early to mid-20th century, psychoanalytic approaches predominated, focusing on underlying psychological conflicts. However, these methods often lacked empirical support, and many patients continued to struggle with their symptoms despite long-term therapy. The 1970s and 1980s marked a significant shift with the emergence of cognitive-behavioral therapy (CBT) and family-based treatment (FBT), each playing a crucial role in the management of different aspects and stages of these complex conditions (Fairburn et al., 1995; Lock et al., 2010).

CBT-ED, or CBT adapted for EDs, has become the most widely studied and utilized treatment for BN and BED, with robust evidence supporting its effectiveness (Wilson et al., 2007). CBT-ED is a broad term that encompasses several types of cognitive behavioral interventions for individuals suffering from an ED and is grounded in the theory that dysfunctional thoughts and behaviors surrounding food, body image, and self-worth are central to the maintenance of the disorder (Fairburn, 2008; Fairburn, Marcus, & Wilson, 1993). CBT-ED treatments typically involve 20 sessions over 5 months, where patients work to identify and challenge problematic cognitions related to eating, develop stable and regular eating patterns, and learn coping strategies. Numerous studies have demonstrated the efficacy of CBT interventions, reporting significant reductions in binge eating and purging behaviors, as well as improvements in associated psychological

symptoms such as depression and anxiety (Murphy et al., 2010; Linardon et al., 2017). For example, a landmark study by Fairburn et al. (1993) found that CBT-ED was superior to interpersonal therapy (IPT) and behavior therapy (BT) in reducing bulimic symptoms at a 1-year follow-up. More recent research has also explored the application of CBT-ED in treating anorexia nervosa, though the evidence suggests it is less effective as a stand-alone treatment for this population, particularly in severe cases (Treasure & Schmidt, 2013). For clarification: throughout this book we reference CBT-ED as well as CBT-E (enhanced cognitive behavior therapy). As stated above, we use the term CBT-ED to refer to a broad range of cognitive behavioral treatments specifically designed to treat EDs. CBT-E (Fairburn, 2008) is a unique CBT-ED that has been widely studied and shown to be effective in the treatment of AN, BN, and BED.

Family-based treatment (FBT), also known as the Maudsley approach, has emerged as a first-line approach for adolescents with AN, emphasizing the critical role of family support in recovery (Lock & Le Grange, 2013). Developed at the Maudsley Hospital in London in the 1970s, FBT involves the entire family in the treatment process, empowering parents to take an active role in restoring their child's weight and normalizing eating behaviors. FBT is typically conducted over 20 sessions across three phases: (1) weight restoration, where parents are supported in refeeding their child; (2) returning control over eating back to the adolescent; and (3) addressing broader family and adolescent issues to support the maintenance of recovery. The effectiveness of FBT has been supported by several randomized controlled trials (RCTs). For instance, a study by Lock et al. (2010) found that FBT was more effective than adolescent-focused therapy (AFT) in achieving full remission of anorexia nervosa symptoms at a 1-year follow-up. The benefits of FBT are particularly pronounced in younger patients and those with a shorter duration of illness, with evidence suggesting that early intervention with FBT can lead to long-lasting recovery (Couturier et al., 2013; Doyle & Le Grange 2019; Madden et al., 2015).

While traditional treatments like CBT and FBT have laid a strong empirical foundation and remain essential components of eating disorder care, they do not sufficiently address the needs of all individuals. In particular, clients with high emotional reactivity, chronic dysregulation, or comorbid conditions often require a more nuanced and flexible approach—one that explicitly targets the emotional and behavioral complexities often seen in those for whom standard approaches are not adequate. Dialectical behavior therapy (DBT) emerged as a compelling candidate to fill this gap.

DBT and Eating Disorders

What Is DBT?

DBT is a sophisticated and integrative therapeutic approach that addresses the nuanced interplay between acceptance and change in individuals with severe emotional and behavioral dysregulation (Linehan, 1993). DBT is a staged treatment that was developed by Marsha Linehan in the late 1980s to treat individuals with recurrent suicidal and self-injurious behaviors, particularly those with borderline personality disorder (BPD). Principle-driven rather than protocol-driven, DBT relies on specific philosophical and theoretical perspectives. The treatment is grounded in dialectical philosophy, which posits that reality is composed of opposing forces and that change occurs through the synthesis of these opposites, rather than by efforts to find the "right" answer or to eliminate what doesn't fit (Linehan, 1993).

In the therapeutic context, dialectics permeates conceptualization and treatment decisions and is embodied in the ongoing balance between accepting the individual's current experiences with the need for behavioral change to improve well-being. By combining cognitive-behavioral strategies with mindfulness and dialectical principles, DBT provides a powerful framework for helping individuals build a life worth living, marked by emotional balance, effective relationships, and a greater sense of inner peace. While most people initially think of the DBT skills as the hallmark feature of the treatment, DBT's application of stylistic, dialectical, and reciprocal strategies truly differentiate it from other treatment paradigms.

It is also important to highlight that DBT is structured into a series of stages that guide the therapeutic process, addressing different levels of dysfunction and helping individuals progress toward a life worth living. These stages are designed to systematically reduce life-threatening behaviors, improve emotional regulation, enhance quality of life, and ultimately help clients achieve goals aligned with their values. Briefly, Stage 1 focuses on achieving behavioral control and reducing life-threatening and severe behavioral issues. Stage 2 addresses past traumas and reduces ongoing emotional pain that tends to reignite Stage 1 behaviors. Stage 3 shifts the focus to improving the quality of everyday life and achieving longer-term personal goals. Stage 4 involves finding a sense of completeness or a deeper sense of meaning and purpose in life. This staged approach allows for a structured and systematic path to recovery, guiding individuals from managing severe behavioral issues to achieving emotional stability and eventually building a

TABLE 1.1 The Stages of DBT

Stage	Challenge	Goal
Stage 1	Severe behavioral dyscontrol	Establishing stability
Stage 2	Quiet misery	Emotional processing and experiencing
Stage 3	Problems in living	Navigating ordinary happiness and unhappiness
Stage 4	Incompleteness	Capacity for sustained joy

fulfilling, meaningful life. Each stage builds upon the last, with the ultimate goal of helping clients not just survive but thrive, by equipping them with the skills and insights needed to lead a balanced and purposeful life (Table 1.1).

Our Personal Path to DBT

DBT caught our attention because of the translational nature of the work to the clients we wanted to treat—patients who do not respond adequately to standard ED care or whose presentations worsened in the context of those models (Touyz et al., 2023). DBT has been extensively researched and is widely recognized for its effectiveness in reducing self-harm, suicidal behaviors, emotional dysregulation, and the need for emergency services or high levels of care (Kliem et al., 2010). Given that so many of our patients struggle with these same symptoms and patterns, utilizing DBT made a lot of sense to us. Given the widespread success of DBT to treat a condition once considered treatment resistant (i.e., BPD), DBT has evolved into a versatile therapeutic approach that is applied to a wide range of psychological conditions characterized by emotional dysregulation, including eating disorders, substance use disorders, and posttraumatic stress disorder (PTSD) (Antuña-Camblor et al., 2024; Lungu & Linehan, 2016). Full DBT treatment, which we reference throughout this book, involves individual DBT therapy, group skills training, phone coaching, and a consultation team meeting for therapists.

The Early Days of MED-DBT

The first significant adaptations of DBT for eating disorders began in the mid-1990s and early 2000s, as clinicians and researchers recognized the overlap between the emotional dysregulation seen in BPD and the patterns of impulsive behavior and emotional distress common in eating disorders. During this period, small-scale studies and case reports began to emerge

focused on modified DBT skills training for bulimia (DBT-BN) and binge-eating disorder (DBT-BED), also referred to as the Stanford model (Safer et al., 2001a and b, 2009). This approach continues to be utilized and studied in patients with BN or BED (Safer et al., 2017; Rahmani et al., 2018) and has been adapted to include a guided self-help option that has been shown to be effective for patients with BED (Masson et al., 2013; Carter, Kennedy, Singleton, Van Wijk, & Heath, 2019).

While we were both interested in this work, we recognized that these frameworks were not designed for the people we wanted to help. The Stanford model and the guided self-help protocol were intended for individuals with primary EDs in the mild to moderate range and focused predominantly on teaching DBT skills in a group or one-on-one context. We view DBT skills as essential, but we believe that those with multidiagnostic presentations require the full DBT framework to maximize success. The dialectical stance, target hierarchy, DBT assumptions, focus on emotional and interpersonal regulation, and the application of DBT skills were highly beneficial, but our clients simultaneously needed help with eating, developing a different relationship with food, managing weight and medical stability, and navigating body image distress.

The model that we have developed draws heavily from the CBT for ED treatment literature, and there is much that is consistent with the CBT for ED model within DBT. That being said, there are many differences between the two models. It has been our personal and professional experience that clinicians who are expertly trained in DBT have no trouble managing suicidality, self-injury, and therapy-interfering behaviors (TIBs), but are prone to fear and avoidance when it comes to weighing their clients, prescribing that they eat three meals and two snacks per day, managing medical instability, or integrating food and fluid intake as part of a diary card. On the other hand, ED therapists are comfortable with the ins and outs of psychoeducation around EDs, managing medical concerns secondary to EDs, and are experts at evaluating a food log but become fearful and avoidant when their client expresses suicidality, engages in self-injurious behaviors, or may ask the client to leave treatment if they engage in therapy-interfering behaviors such as water loading or refusing to eat.

Our work was bolstered by several other studies at that time that demonstrated promise in the adapted use of DBT for patients with multidiagnostic EDs. Results from case series designs showed feasibility, acceptability, reductions in purging behaviors and binge eating, and improvements in mood, emotion regulation, and treatment retention among those who had

not responded to frontline ED approaches (Ben-Porath et al., 2009; Chen et al., 2008; Kröger et al., 2010; Palmer et al., 2003; Salbach-Andrae et al., 2008; see review by Bankoff et al., 2012).

Together, we delivered, refined, and evaluated the MED-DBT protocol in both adult (Federici et al., 2012; Federici & Wisniewski, 2013) and adolescent (Federici & Wisniewski, 2012) populations. We spent a great deal of time reading, consulting, and discussing alternative treatment models, including specialist supportive clinical management (SSCM) and radically open DBT (RO-DBT). While both contained elements that were helpful (e.g., a focus on quality of life, targeting rigidity and social signaling), these protocols were still not sufficient for the needs of our patients. The program we implemented and evaluated entailed a minimum commitment to 6 months of MED-DBT where patients attended either day treatment programming (6 hours/day, 5 days/week) or intensive outpatient programming (IOP; 3 hours/day, 3–5 days/week). Predominantly group-based, patients attend weekly individual DBT therapy, regular nutrition and psychiatry appointments, and have access to between-session skills coaching.

The case series we published in 2013 followed seven women with longstanding and multidiagnostic EDs over 6 months (Federici & Wisniewski, 2013). Treatment completion for all of the patients was associated with reductions in ED symptoms, suicidal and self-injurious behaviors, therapy-interfering behaviors, psychiatric and medical hospitalizations, and clinician burnout (Federici & Wisniewski, 2013). The feedback we received from patients and staff was inspiring and we were motivated by the manner in which the model reinvigorated treatment for people who felt little else could be done for them. We continued to explore how the model impacted affect regulation (Ben-Porath et al., 2014), what skills were more impactful at meals (Marek et al., 2013), and how to utilize contingency management protocols and establishing novel dialectical dilemmas specific to our patients (Wisniewski & Ben-Porath, 2015).

What about RO-DBT?

An alternative framework, RO-DBT (radically open DBT), has emerged as a possible treatment pathway for patients with anorexia who present as emotionally overcontrolled. Certainly, across ED diagnoses, some patients struggle with low novelty-seeking (Rossier et al., 2000), heightened threat sensitivity (Harrison, Sullivan, Tchanturia, & Treasure, 2010), low sensitivity to reward (Harrison, O'Brien, Lopez, & Treasure, 2010), cognitive

rigidity (Tchanturia et al., 2012), inhibited emotional expression/recognition (Geller, Cockell, Hewitt, Goldner, & Flett, 2000), and loneliness (Zucker et al., 2007). RO-DBT theorizes that these bio-temperamental characteristics cause and maintain ED behaviors (Hemple et al., 2018). This specific theory of overcontrol as it applies to restrictive ED behaviors has yet to be empirically tested; however, several studies have been published showing promising outcomes including a case study (Little & Codd, 2020); an open, uncontrolled trial of 47 patients on an inpatient ED unit (Lynch et al., 2013), a qualitative analysis (Isaksson et al., 2021); an uncontrolled study of 131 adolescents in a day treatment setting in which RO-DBT groups were embedded (Baudinet et al., 2020); and an outpatient feasibility study of 23 patients with AN (Ejdemyr et al, 2025).

While promising, these studies have excluded patients with low body weights, those with binge/purge behaviors, cognitive difficulties, BPD symptoms and, in some cases, patients needing more intensive ED support or those who had recently participated in other treatments. In the two larger studies commonly cited to support the use of RO-DBT for anorexia nervosa restricting type (AN-R), patients were concurrently involved in high levels of ED care where weight, eating, and other ED interventions were employed. Given the lack of a waitlist control group or randomized controlled trial, it is difficult to determine whether the observed improvements are due to the passage of time, more traditional ED interventions, nonspecific effects of general inpatient or outpatient treatment, or the specific impact of RO-DBT (Ben-Porath et al., 2020).

In our own training/consultation with the RO-DBT treatment developers, we struggled to make it work for our clients. It is our view that RO-DBT may be a useful treatment for some patients as a Stage 3 treatment but not as a Stage 1 or 2 model (see Thomas et al., 2024). Our clients require intensive support to stay alive, including maintaining medical stability alongside reducing suicidal and self-injurious behaviors. They need help reducing the behaviors that get in the way of participating in treatment, including cognitive challenges secondary to food restriction and weight loss. They require a model that can help them manage emotions (including fear, disgust, and envy), especially around food, meal planning, and navigating weight gain or other bodily sensations that are distressing. Moreover, we have found that emotional overcontrol and undercontrol tendencies coexist in our patients. We are not convinced that these are binary constructs, rather that our patients can and do experience both. For example, our clients can present as highly overcontrolled until they have to eat or gain weight.

Summary

Over the past 15 years, we have seen an increase in the number of published studies showing that MED-DBT reduces both ED and BPD symptoms and increases treatment engagement across levels of care including outpatient (Courbasson et al., 2012; Liakopoulou et al., 2023; Navarro-Haro et al., 2018), day treatment (Brown et al., 2018; McColl, Donkin, & Hindle, 2024; Pennell et al., 2019), and partial hospitalization (Brown et al., 2019a, 2019b). Several research groups are currently working on more robust clinical trials for MED-DBT, and it will be important to continue to modify or adapt our model based on the evolving literature. The information in this chapter will be important for you to share with your client as needed and to weave into early discussions about why they might consider MED-DBT compared to other available models. In the following chapter, we walk you through our criteria for MED-DBT and recommendations for assessing suitability.