Interpersonal Psychotherapy for the Treatment of Eating Disorders

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Abstract and Keywords

Interpersonal psychotherapy (IPT) is a focused, time-limited treatment that targets interpersonal problem(s) associated with the onset and/or maintenance of EDs. IPT is supported by substantial empirical evidence documenting the role of interpersonal factors in the onset and maintenance of EDs. IPT is a viable alternative to cognitive behavior therapy for the treatment of bulimia nervosa and binge eating disorder. The effectiveness of IPT for the treatment of anorexia nervosa requires further investigation. The utility of IPT for the prevention of obesity is currently being explored. Future research directions include enhancing the delivery of IPT for EDs, increasing the availability of IPT in routine clinical care settings, exploring IPT for adolescent and parent-child adaptations, and developing IPT for the prevention of eating and weight-related problems that may promote full-syndrome EDs or obesity.

Keywords: eating disordered symptoms, interpersonal relationships, obesity, social functioning

Introduction

Interpersonal psychotherapy (IPT) is a brief, time-limited therapy that focuses on improving interpersonal functioning and, in turn, psychiatric symptoms, by relating symptoms to interpersonal problem areas and targeting strategies to improve these problems (Freeman & Gil, 2004; Klerman, Weissman, Rounsaville, & Chevron, 1984). Originally developed by Gerald Klerman and colleagues (Klerman et al., 1984) for the treatment of unipolar depression, IPT is an efficacious treatment for bulimia nervosa (BN) (Fairburn et al., 1991; Fairburn, Peveler, Jones, Hope, & Doll, 1993) and binge eating disorder (BED) (Wilfley et al., 1993; Wilfley, Frank, Welch, Spurrell, & Rounsaville, 1998). There are limited data from randomized-controlled trials on the effectiveness of IPT in the treatment of anorexia nervosa (AN).

The current chapter provides an overview of interpersonal theory and its foundation for IPT. Following this is a brief review of the literature supporting the central role that interpersonal functioning plays in the development, manifestation, and maintenance of eating disorders (EDs). The delivery of IPT for EDs also is explained, along with a description of the major tenets of the treatment. Empirical evidence supporting IPT’s efficaciousness for the treatment of BN and BED is reviewed, as well as the limited data on the use of IPT for AN. A discussion of a novel adaptation of IPT for obesity prevention follows. Where appropriate, we provide vignettes as examples. Finally, more recent changes to the delivery of IPT are described, and future directions are proposed.

Interpersonal Theory

IPT is grounded in theories developed by Meyer, Sullivan, and Bowlby, which hypothesize that interpersonal function is recognized as a critical component of psychological adjustment and well-being. In the 1950s, Meyer postulated that psychopathology was rooted in maladjustment to one’s social environment (p. 348) (Frank & Spanier, 1995; Klerman et al., 1984; Meyer, 1957). During the same time period, Sullivan (who was responsible for popularizing the term “interpersonal”) theorized that a patient’s interpersonal relationships, rather than intrapsychic processes alone, established the relevant focus of therapeutic attention. Sullivan believed that individuals could not be understood in isolation from their interpersonal relationships and posited that enduring patterns in these relationships could either encourage self-esteem or result in anxiety, hopelessness, and psychopathology. IPT is also associated with the work of John Bowlby (1982) originator of attachment theory. Bowlby emphasized the importance of early attachment to the later development of interpersonal relationships and emotional well-being. He also hypothesized failures in attachment resulted in later psychopathology. The interpersonal roles of major interest to IPT occur within the nuclear family (as parent, child, sibling, partner); the extended family; the friendship group; the work situation (as supervisor, supervisee, or peer); and the neighborhood or community. Incorporating aspects of the theories posited by Meyer, Sullivan, and Bowlby, IPT acknowledges a two-way relationship between social functioning and psychopathology: disturbances in social roles can serve as antecedents for psychopathology and mental illness can produce impairments in the individual’s capacity to perform social roles (Bowlby, 1982).

Incorporating the work of these interpersonal theorists, IPT acknowledges a two-way relationship between social functioning and psychopathology: interpersonal dysfunction heightens risk for psychopathology, and psychopathology results in deterioration of interpersonal functioning. Therefore, IPT is derived from a theory in which interpersonal functioning is recognized as a critical component of psychological adjustment and well-being. It should be noted that IPT makes no assumptions about the causes of psychiatric illness; however, IPT does assume that the development and maintenance of some psychiatric illnesses occurs in a social and interpersonal context and that the onset, response to treatment, and outcomes are influenced by the interpersonal relations between the patient and significant others. We will describe the major tenets of IPT for EDs in this chapter. However, the extensive empirical background and theoretical foundation, as well as the strategies and techniques of IPT, are fully described in a comprehensive book by Myrna Weissman and her colleagues (Weissman, Markowitz, & Klerman, 2000).

Interpersonal Functioning and EDs
A consistent relationship between poor interpersonal functioning and EDs has been identified (Wilfley, Stein, & Welch, 2005). Individuals with EDs report past difficult social experiences, problematic family histories, and specific interpersonal stressors more often than non–eating disordered individuals (Fairburn et al., 1998; Fairburn, Welch, Doll, Davies, & O’Connor, 1997). Individuals with bulimic symptoms tend to experience a wide range of social problems, including loneliness, lack of perceived social support, poor self esteem and social adjustment, and also often demonstrate difficulty with social problem-solving skills (Crow, Agras, Halmi, Mitchell, & Kraemer, 2002; Ghaderi & Scott, 1999; Grissitt & Norvell, 1992; Gual et al., 2002; Johnson, Spitzer, & Williams, 2001; O’Mahony & Hollway, 1995a; Rorty, Yager, Buckwalter, & Rossotto, 1999; Steiger, Gauvin, Jabalpurwala, Seguin, & Stotland, 1999; Troop, Holbrey, Towler, & Treasure, 1994; Wilfley, Wilson, & Agras, 2003). Heightened sensitivity to interpersonal interactions appears to be a common component among individuals with symptoms of EDs (Evans & Wertheim, 1998; Humphrey, 1989; Steiger et al., 1999; Tasca, Taylor, Ritchie, & Balfour, 2004; Troisi, Massaroni, & Cuzzolano, 2005). Laboratory paradigms suggest that interpersonal distress may trigger overeating (Steiger et al., 1999; Tanofsky-Kraff, Wilfley, & Spurrell, 2000) and potentially perpetuate binge eating. Further, interpersonal difficulties, low self-esteem, and negative affect are likely interconnected in a reciprocal fashion (Fairburn et al., 1997, 1998; Gual et al., 2002) and serve to perpetuate a cycle with each factor exacerbating the other and combining to precipitate and/or maintain dysfunctional bulimic or binge eating patterns (Herzog, Keller, Lavori, & Ott, 1987). Individuals with AN also report difficulties with psychosocial functioning (O’Mahony & Hollway, 1995b; Rusuksa, Kolvisto, Rantanen, & Kalliala-Heino, 2007) compared to controls and individuals at elevated risk for EDs (O’Mahony & Hollway, 1995b). Therefore, in theory, the use of an interpersonal-focused intervention appears to be especially suitable for the treatment of EDs. IPT is designed to improve interpersonal functioning and self-esteem, reduce negative affect, and, in turn, decrease ED symptoms.

IPT for EDs

Basic IPT Concepts

IPT has been adapted for a range of clinical disorders (Weissman et al., 2000), but a number of basic concepts are common across all adaptations of IPT, (p. 350) including treatment for EDs. Specifically, adaptations for IPT all focus on interpersonal problem areas and maintain a similar treatment structure. Given the time-limited nature of IPT, treatment success hinges on the therapist’s rapid discernment of patterns in interpersonal relationships and the linking of these patterns to symptoms that may have precipitated and continue to maintain the disorder. Thus, in IPT for the treatment of EDs, treatment centers on facilitating clients’ awareness of the links among their relationship interactions, negative affect, and disordered eating symptoms. Early identification of the problem area(s) and treatment goals by the therapist and patient is crucial. Throughout every session, interpersonal functioning is continuously linked to the onset and maintenance of the ED.

Interpersonal Problem Areas

A primary aim of IPT is to help patients identify and address current interpersonal problems. By focusing on current as opposed to past relationships, IPT makes no assumptions about the etiology of an ED. Treatment focuses on the resolution of problems within four social domains that are associated with the onset and/or maintenance of the ED: (1) interpersonal deficits, (2) interpersonal role disputes, (3) role transitions, and (4) grief. Interpersonal deficits apply to those patients who are either socially isolated or who are involved in chronically unfulfilling relationships. For clients with this problem area, unsatisfying relationships and/or inadequate social support are frequently the result of poor social skills. Interpersonal role disputes refer to conflicts with a significant other (e.g., a partner, other family member, coworker, or close friend) that emerge from differences in expectations about the relationship. Role transitions include difficulties associated with a change in life status (e.g., graduation, leaving a job, moving, marriage/divorce, retirement, changes in health). The problem area of grief is identified when the onset of the patient’s symptoms is associated with either the recent or past loss of a person or a relationship. Making use of this framework for defining one or more interpersonal problem areas, IPT for EDs focuses on identifying and changing the maladaptive interpersonal context in which the eating problem has developed and been maintained. The four problem areas are discussed in detail in the section describing the “Intermediate Phase.”

Treatment Structure

IPT for EDs is a time-delineated treatment that typically includes 15 to 20 sessions over 4 to 5 months. Regardless of the exact number of sessions, IPT is delivered in three phases. The initial phase is dedicated to identifying the problem area(s) that will be the target for treatment. The intermediate phase is devoted to working on the target problem area(s). The termination phase is devoted to consolidating gains made during treatment and preparing patients for future work on their own.

Implementing IPT for EDs

The Initial Phase

Sessions 1 to 3 typically constitute the initial phase of IPT for EDs. The patient’s current ED symptoms are assessed and a history of these symptoms is obtained. The clinician provides the patient with a formal diagnosis. The ED diagnosis and expectations for treatment are discussed. An assignment of the “sick role” (described in further detail later) during this phase serves several functions, including granting the patient the permission to recover, delineating recovery as a responsibility of the patient, and allowing the patient to be relieved of other responsibilities in order to recover. The therapist explains the rationale of IPT, emphasizing that therapy will focus on identifying and altering current dysfunctional interpersonal patterns related to ED symptomatology. To determine the precise focus of treatment, the clinician conducts an “interpersonal inventory” with the patient and, in doing so, develops an interpersonal formulation that specifically relates to the patient’s ED. In the interpersonal formulation, the therapist links the patient’s ED to at least one of the four interpersonal problem areas. The patient’s concurrence with the clinician’s identification of the problem area and agreement to work on this area are essential in order to begin the intermediate phase of treatment. Indeed, a collaborative effort is promoted throughout the interpersonal inventory and all therapy sessions.

Diagnosis and Assignment of the Sick Role

After a psychiatric assessment, the patient is formally diagnosed with an ED and assigned what is termed the “sick role.” The assignment of the sick role is theoretical and serves a practical purpose. Consistent with the medical model, receiving a formal diagnosis reinforces the understanding that the patient has a known condition that can be treated. Accurate diagnosis is essential to successful treatment. Providing a diagnosis also explicitly identifies the patient as being in need of help. The sick role is assigned not to demean the patient but rather to temporarily exempt the individual from other responsibilities in order to devote full attention to recovery. This is particularly important for individuals with a tendency to set aside their own needs and desires in order to care for and please others. If appropriate, the IPT therapist might explicitly highlight the patient’s excessive...
caretaking tendencies and encourage the patient to redirect this energy from others toward self-recovery.

The Interpersonal Inventory
A primary and critical component of the initial phase of IPT is the interpersonal inventory. The interpersonal inventory involves a thorough examination of the patient’s interpersonal history. Although clinicians have historically taken up to three sessions to complete the interpersonal inventory, we have found that conducting a longer (approximately 2-hour) first session to complete the entire interpersonal inventory may increase the effectiveness of the treatment. This is likely because it allows for patients to get “on board” early in terms of their understanding of IPT and how their ED fit into the IPT rationale (Tanofsky-Kraft & Wilfley, 2010; Wilfley, 2008; Wilfley, Mackenzie, Welch, Ayres., & Weissman, 2000). The interpersonal inventory is essential for adequate case formulation and development of an optimal treatment plan. The clinical importance of investing the time to conduct a comprehensive interpersonal inventory cannot be overemphasized; accurate identification of the patient’s primary problem area(s) is often complicated and is crucial to success in treatment. Table 20.1 illustrates the tasks that should ideally be covered during the first session (Dounchis, Welch, & Wilfley, 1999).

The interpersonal inventory involves a review of the patient’s current close relationships, social functioning, relationship patterns, and expectations of relationships. Interpersonal relationships—both patterns and changes—are explored and discussed with reference to the onset and maintenance of ED symptoms. For each significant relationship, the following information is assessed: frequency of contact, activities shared, satisfactory and unsatisfactory aspects of the relationship, and ways that the patient wishes to change the relationship. The therapist obtains a chronological history of significant life events, fluctuations in mood and self-esteem, interpersonal relationships, and ED symptoms. Throughout this process, the therapist works collaboratively with the patient to make connections between life experiences and ED development and symptoms. This exploration provides an opportunity for the patient to clearly understand the relationship between life

<table>
<thead>
<tr>
<th>Table 20.1 Tasks of the Initial Session(s)</th>
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<tbody>
<tr>
<td>Discuss chief complaint and eating disorder symptoms.</td>
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<tr>
<td>Obtain history of symptoms.</td>
</tr>
<tr>
<td>Place patient in the sick role.</td>
</tr>
<tr>
<td>Establish whether or not there is a history of prior treatments for the eating disorder or other psychiatric problems.</td>
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<tr>
<td>Assess patient’s expectations about psychotherapy.</td>
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<tr>
<td>Reassure patient about positive prognosis.</td>
</tr>
<tr>
<td>Explain IPT and its basic assumptions.</td>
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<tr>
<td>Complete an Interpersonal Inventory (detailed review of important relationships):</td>
</tr>
<tr>
<td>I. Review past interpersonal functioning (e.g., family, school, social).</td>
</tr>
<tr>
<td>II. Examine current interpersonal functioning (e.g., family, work, social).</td>
</tr>
<tr>
<td>III. Identify the interpersonal precipitants of episodes of eating disorder symptoms.</td>
</tr>
<tr>
<td>Translate eating disorder symptoms into interpersonal context.</td>
</tr>
<tr>
<td>Explain IPT and its techniques.</td>
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<tr>
<td>Contract for administrative details (i.e., length of sessions, frequency, duration of treatment, appointment times).</td>
</tr>
<tr>
<td>Provide feedback to patient regarding general understanding of her interpersonal difficulties via IPT problem area (i.e., define interpersonal deficits - loneliness and social isolation).</td>
</tr>
<tr>
<td>Collaborate on a contract regarding the treatment goals.</td>
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<tr>
<td>Explain tasks in working toward treatment goals.</td>
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</tbody>
</table>


Table 20.2 Example of a Personal Historical Timeline of a Patient with BED

<table>
<thead>
<tr>
<th>Age</th>
<th>Problems</th>
<th>Relationship</th>
<th>Events/Circumstances</th>
<th>Moods</th>
</tr>
</thead>
</table>

events, social functioning, and the ED, and thereby clarifies the rationale behind IPT. Upon completion of the interpersonal inventory, the therapist and patient collaboratively identify a primary interpersonal problem area. In some cases, more than one problem area may be identified. Table 20.2 illustrates an example of a “Life Chart” (Fairburn, 1997) developed by an individual with BED and the therapist during the interpersonal inventory (Wilfley, 2008, Wilfley et al., 2000).
5 Normal weight. Tonsils are removed.

6 Begins gaining weight.

14 Grandfather died. Feels sad at funeral but does not cry because she thinks it would be a sign of weakness.

15 Concerns about weight; first binge; prescribed amphetamines to lose weight. Sister gets married, borrows money from parents, and files for bankruptcy with her husband. Perceives parents as being extremely disappointed in sister.

16 Less concern about weight because “boyfriend’s ex-wife was a lot heavier than me” but began binge eating. Meets boyfriend, 23, who works at a gas station. Does not tell parents about boyfriend given father’s high-profile job and position in the community. Fearful of parents’ disappointment; worries about their finding out.

18 Binge eating when alone Loses weight. Becomes engaged. Tells sisters, not parents. Boyfriend breaks off the engagement. Graduates from high school; goes to technical school. Abortion Boyfriend “steals” back the ring (seen on his new girlfriend); throws herself into work as a secretary; is promoted repeatedly. More comfortable about weight (“boyfriend’s wife was a lot heavier than me”). Binge eating when alone (“food was my only friend when he was away”); never ate when with him. Meets new boyfriend, who works as a salesman; he says he is separated from his wife who is pregnant. Lies to family and friends, telling them that they got married. Spouse of coworker tells her he is cheating on her. Boyfriend’s wife pickets her parents’ house; parents do not make mention of this. Moves to Minnesota with boyfriend. Throws boyfriend out of the house; on his way out he takes her ring from her jewelry box. Does not feel guilty about the relationship. Secrecy (wanting to be “perfect and not disappoint my parents”); homesick.

27 Binge eating as an outlet. Gets pregnant, marries the father, an alcoholic, who is “cruel and verbally abusive.” Lies to mother that she got pregnant after the wedding; birth of first child. Compliant, scared.

28 Husband occasionally shoves her. “I channeled my energy into my son.” Hateful.

32 “Eating a lot” Husband hits her; she stands up to husband only once, to ask him to choose between her and alcohol. Husband no longer drinks but continues being verbally abusive. Has sex with husband approximately two times a year. Husband invests $20,000 of their joint money in real estate—all money lost; patient begins saving “every penny,” sending $5,000 to her sister to open a savings account; became a workaholic. Fearful husband will hit her; obedient; proud at holding onto her feelings; derives esteem from keeping her trouble from her children and others.

39 Eating as a way to “hold everything together.” Sexual relationship with husband ends; although she does not express anger, he yells at her, saying he can do whatever he wants with his money.

41 260 lb., highest weight Marital therapy with clergy for 3 months.
## Problem Areas

### Grief

Grief is identified as the problem area when the onset of the patient’s symptoms is associated with the death of a loved one, either recent or past. Grief is not limited to the physical death of a loved one. Grief can also result from the loss of a significant relationship or the loss of an important aspect of one’s identity. The goals for treating complicated bereavement include facilitating mourning and helping the patient to find new activities and relationships to substitute for the loss. Reconstructing the relationship, both the positive and its negative aspects, is central to the assessment of not only what has been lost but also what is needed to counter the idealization that so commonly occurs. As patients become less focused on the past, they should be encouraged to consider new ways of becoming more involved with others and establishing new interests (Wilfley et al., 2005). The distribution of the IFT problem areas among individuals with EDs has been reviewed by Wilfley and colleagues (2003). For 12% of BN patients, grief has been identified as their primary problem area, while approximately 6% of individuals with AN and 6% with BED present with grief.

### Role Transitions

Role transition includes any difficulties resulting from a change in life status. Common role transitions include a career change (i.e., promotion, firing, retirement, changing jobs), a family

<table>
<thead>
<tr>
<th>Week</th>
<th>Event</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>47</td>
<td></td>
<td>Loses 60 lbs.</td>
</tr>
<tr>
<td>50</td>
<td></td>
<td>Meets current boyfriend.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Mother dies.</td>
</tr>
<tr>
<td>51</td>
<td></td>
<td>Regains 30 lbs.</td>
</tr>
<tr>
<td>52</td>
<td></td>
<td>Binge eating at night on objectively large amounts of food at least three times per week. Begins psychotherapy</td>
</tr>
</tbody>
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Table 20.3 Interpersonal Problem Areas

<table>
<thead>
<tr>
<th>Main Problem Area</th>
<th>Description</th>
<th>IPT Strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grief</td>
<td>Pathological grief stemming from fears of being unable to tolerate the painful affect associated with the loss.</td>
<td>Facilitate the mourning process. Help the patient reestablish interest in relationships to substitute for what has been lost.</td>
</tr>
<tr>
<td>Interpersonal role disputes</td>
<td>Disputes with partner, children, or other family members or coworkers.</td>
<td>Identify the dispute. Choose a plan of action. Modify expectations and faulty communication to bring about a satisfactory resolution.</td>
</tr>
<tr>
<td>Role transitions</td>
<td>Economic or family change: children leaving for college, new job, divorce, retirement, parent’s caretaker.</td>
<td>Mourn and accept the loss of the old role. Restore self-esteem by developing a sense of mastery regarding the demands of new roles.</td>
</tr>
<tr>
<td>Interpersonal deficits</td>
<td>A long-standing history of social isolation, low self-esteem, loneliness, and an inability to form or maintain intimate relationships.</td>
<td>Reduce the patient’s social isolation. Encourage the formation of new relationships.</td>
</tr>
</tbody>
</table>


(p. 355) Change (marriage, divorce, birth of a child, child moving out), the beginning or end of an important relationship, a move, graduation, or diagnosis of a medical illness. The goals of therapy include mourning and accepting loss of the old role, recognizing the positive and negative aspects of both the old and new roles, and restoring the patient’s self-esteem by developing a sense of mastery in the new role. Key strategies in achieving these goals will include a thorough exploration of the patient’s feelings related to the role change as well as encouraging the patient to develop new skills and adequate social support for the new role (Wilfley et al., 2005). Thirty-six percent of patients with BN (Wilfley et al., 2003) and 3.7% of individuals with BED in Wilfley and colleagues’ (2000) trial were identified with the problem area of role transitions. Among individuals with AN, approximately 17% present with role transitions as the primary problem area (Wilfley et al., 2003).

Interpersonal Role Disputes

Such disputes are conflicts with a significant other (e.g., partner, other family member, employer, co-worker, teacher, or close friend), which emerge from differences in expectations about the relationship. The goals of treatment include clearly identifying the nature of the dispute and exploring options to resolve it. It is important to determine the stage of the dispute: once the stage of the dispute becomes clear, it may be important to modify the patient’s expectations and remedy faulty communication in order to bring about adequate resolution. It may be particularly helpful to explore how nonreciprocal role expectations relate to the dispute. If resolution is impossible, the therapist assists the patient in dissolving the relationship and in mourning its loss (Wilfley et al., 2005). This problem area is identified in approximately 64% of individuals with BN and 33% of those with AN (Wilfley et al., 2003). Interpersonal role disputes were present in 29.6% of the patients in the Wilfley et al. (2000) BED trial.

Interpersonal Deficits

Interpersonal deficits include patients who are socially isolated or who are in chronically unfulfilling relationships. The goal is to reduce the patient’s social isolation by helping enhance the quality of existing relationships and encouraging the formation of new relationships. To help these patients, it is necessary to determine why they have difficulty in forming or maintaining relationships. Carefully reviewing past significant relationships will be particularly useful in making this assessment. During this review, attention should be given to both the positive and negative aspects of the relationships, as well as an investigation of potentially recurrent patterns in these relationships. It may also be appropriate to examine the nature of the patient-therapist relationship, since this may be the patient’s only close relationship and it is present to be observed (Wilfley et al., 2005). For patients with BN and AN, this problem area is seen in approximately 16% and 33%, respectively (Wilfley et al., 2003). Based upon one study, interpersonal deficits appeared to be the most commonly identified problem area among individuals with BED; 60.5% of patients presented with interpersonal deficits (Wilfley et al., 2000).

Therapeutic Strategies

Therapeutic Stance

As with most therapies, IPT places importance on establishing a positive therapeutic alliance between therapist and patient. The IPT therapeutic stance is one of warmth, support, and empathy. Further, throughout all phases of the treatment, the clinician is active and advocates for the patient rather than remaining neutral. Issues and discussions are framed positively so that the therapist may help the patient feel at ease throughout treatment. Such an approach promotes a safe and supportive working environment. Confrontations and clarifications are offered in a gentle and timely manner, and the clinician is careful to encourage the patient’s positive expectations of the therapeutic relationship. Finally, the therapist conveys a hopeful and optimistic attitude about the potential for the patient to recover.

Focusing on Goals

Because IPT is a directed, goal-oriented therapy, therapists should maintain a focus each week on how the patient is working on his or her agreed-upon goals between sessions. Phrases such as “moving forward on your goals” and “making important changes” are used to encourage patients to be responsible for their treatment while also reminding them that altering interpersonal patterns requires attention and persistence. Sometimes during the course of therapy, unfocused discussions arise. The therapist should sensitively, but firmly, redirect the discussion to the key interpersonal issues.
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By explicitly addressing goals each week, the patient can work toward necessary changes. This goal-oriented focus has been supported by research on IPT maintenance treatment for recurrent depression, which has demonstrated that the clinician’s ability to maintain focus on interpersonal themes is associated with better outcomes (Kleiman et al., 1984; Markowitz, Skodol, & Bleiberg, 2006; Weissman et al., 2000). In IPT for EDs, it is essential that the clinician facilitate and strengthen the recognition of connections between patients’ problematic eating and difficulties in their interpersonal lives. The example below illustrates how the IPT therapist initiates the discussion about goals and helps a patient in treatment for BN with interpersonal deficits on her goals.

Therapist: Ellie, I would like to check in with you to see how your work on your goals is progressing. Last week, you mentioned that you are starting to become more aware of interpersonal difficulties that trigger your binge eating and purging.

Ellie: I have been paying more attention to what is happening when I binge. It seems as though there are a lot of times that I feel the urge to binge, whether it is feeling put down at work, angry at my husband, or feeling overwhelmed about taking care of the kids. I think that I am beginning to better understand what happens with me when I get the urge to binge. I feel overwhelmed – I have so much going on in my life, I do not know how I will ever overcome the desire to binge.

Therapist: I imagine that it must feel very frightening when you have so much going on – it can seem as though gaining control over your eating might be impossible. However, you have taken a very important first step, Ellie. It is great that you have begun to identify triggers to your binge eating. From your work, it is clear that a lot of things are playing into your desire to binge. How were you able to become more aware of what was happening with you when you felt the urge to binge?

Ellie: I think that instead of just binge eating as soon as I feel the urge, I think I have become aware that something changes for me when I have the urge to binge. Lately, I have been trying hard to stop and see what is going on and what I am feeling before I binge. Even though I have still had binge episodes this week, I think that at least once or twice I seemed to have lost the desire to binge once I stopped and thought about what was going on in that moment.

Therapist: What specifically did you notice was happening with you?

Ellie: I noticed that I was feeling frustrated about my work and how angry I feel at my husband when he makes me feel like I am an inadequate wife and parent. I realized that I often do not stand up for myself and let the people in my life know what my needs are. I don’t feel like I know how to do this and end up expressing—or is it suppressing?—my frustration through food.

Therapist: This is very important work you are doing, Ellie – good job! You have identified some really important interpersonal triggers for your binge eating. As you continue to become more and more aware of the circumstances surrounding your urge to binge, we can begin to work on helping you find more effective ways to manage your feelings and relationships so that you are less likely to binge.

As this dialogue between Ellie and her therapist illustrates, a crucial component to IPT for EDs is helping to facilitate and strengthen the connections patients make between their problematic eating and difficulties they have in their interpersonal lives. Focusing on specific goals provides the structure for this to be accomplished. Ellie’s ability to have insight to make links between her interactions, mood, and disordered eating is due to the therapist’s persistence in emphasizing the connection between Ellie’s interpersonal functioning to her eating patterns throughout all phases of the treatment.

Making Connections

During the intermediate phase, it is crucial that the therapist assist patients in recognizing, and ultimately becoming more aware of, the connections between eating difficulties and interpersonal events during the week. As patients learn to make these connections, the therapist should guide them to develop strategies to alter the interpersonal context in which the disordered eating symptoms occur. As a result, the cycle of the ED is interrupted. Patients are encouraged to make connections between interpersonal functioning and eating patterns that are positive as well. For example, an individual may recognize that communication improved with a significant other and, as a result, the patient did not engage in ED behaviors. To encourage positive and negative connections, clinicians should ask the patient about his or her eating patterns between sessions and, if there were any changes, inquire about any recognized links between eating patterns and interpersonal functioning.

In the following vignette, which is also in the intermediate phase, the therapist encourages a patient with interpersonal role disputes in treatment for AN to talk about the connections she has made between her desire to restrict her food intake and difficulties she experiences with her divorced parents:

Therapist: Ashley, have you noticed any connections between your eating and how things went with your parents this past week?

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Ashley: Well, my parents have been arguing a lot—mostly about where I am going to spend the summer vacation. I just can’t stand it. Whenever they talk badly about the other to me, I’m not hungry at all and I just want to starve myself. Maybe this is a way to make them notice how their fighting gets to me. I don’t know.

Therapist: This is terrific work Ashley! One of the things we have been working on is getting you to become more aware of what is happening when you feel the urge to restrict most intensely. You have just made an important connection between your stress and dislike related to your parents arguments and your wanting to restrict. How do you think restricting your eating affects your mood?

Ashley: Well, focusing on not eating helps me not to think about all the stuff going on between my parents. I feel kind of numb. I guess I never realized that connection until we started working together. All I cared about was how much I wanted to be thin.

Therapist: Now that you can more clearly see that connection, how would you like to start working on your relationships with your mother and father?

Redirecting Issues Related to ED Symptoms

During treatment sessions, patients with EDs may raise issues relating to ED symptoms that are distressing (e.g., binge episodes, over-concern about eating, shape, and weight) or want to engage in extended discussion related to these behaviors. These issues are relevant insofar as they reflect the clinical status of the patient’s ED. However, the therapist must be cognizant of how these issues are being discussed during the sessions and vigilantly keep the session focused on the patient’s treatment goals by gently, but firmly, redirecting discussion to work on the treatment goals. For example, a female patient who avoids intimacy with her husband may attribute her avoidance to body dissatisfaction related to her obesity. She may wish to
discuss her body concerns at great length to circumvent actual difficulties in communication with her husband, or she is not yet aware that her relationship difficulties with her husband is an important issue and that body concern is what she experiences as most distressing. Dialogue related to ED symptoms should be consistently and repeatedly linked to its functional role with regard to the identified interpersonal problem area(s).

**Therapist:** How are you today, Terry?

**Terry:** I have been busier than usual and that has made me very stressed. I was asked to cover the late shift twice this week and since we have been understaffed, I was the only one to cover all of the patients during my shift. I had no time to eat dinner, which was probably good for me, but then I came home both nights and had huge binges. I found myself in the kitchen eating anything and everything that I could find. I was so frantic that I didn’t even bother to heat up—I ate a huge container of soup cold!

**Therapist:** Last week you talked about how eating is a way for you to relieve stress and to relax. Instead of allowing yourself a break or sharing your feelings with family or friends, you tend to turn to food.

**Terry:** That is exactly what I do—and what I did this week. It was unbelievable and I was so disgusted with how I was shoving food in by the mouthful—cookies, chips, leftover pizza. Have you ever eaten cold pizza? It doesn’t even taste good! I just wanted...

**Therapist:** I am going to interrupt you for a moment, Terry, so that I can refocus you for a moment, back to your goals. How has your work in finding down time to take care of yourself been coming along?

**Terry:** I think it has been going somewhat better. I signed up to join a book club through my church. It hasn’t started yet, but I did go buy the book we’re supposed to read and I started reading a few pages. I’m hoping that my work schedule does not conflict with the nights that the club will be meeting.

**Therapist:** As we talked about last week, for a long time you’ve been feeling that you need to take care of everyone else—make everyone else happy—and, in doing so, you’ve put yourself last and not tended to your own needs. By not taking care of yourself, you get very stressed and use food to cope. I wonder if as you practice identifying your own needs and addressing them—like you have in joining the book club—you will feel less exhausted and more personally cared for. By taking time out for yourself, you will feel calmer and be less likely to turn to food. Joining the book club and beginning to read is already one way you are taking care of yourself. I have noted that you only had two overeating episodes this past week. When we first started working together, you were having binge episodes almost nightly during similarly stressful times.

By redirecting the patient away from the specifics of her binge episode, and toward her interpersonal problem area, the therapist is able to keep the patient focused on her goals.

(p. 358) General Therapeutic Techniques

The IPT differs from providers of other modalities in that throughout the course of treatment, he/she maintains a constant focus on the interpersonal context of the patient’s life and its link to the ED symptoms. Although this approach is unique to IPT, a number of the therapeutic techniques utilized in IPT are similar to those used in other therapies. Such techniques include exploratory questions, encouragement of affect, clarification, communication analysis, and use of the therapeutic relationship.

1. **Exploratory questions.** Use of general, open-ended questions often facilitates the free discussion of material. This is especially useful during the beginning of a session. For example, the clinician might open a session with, “Tell me about your relationship with your husband.” Once this has generated discussion, progressively more specific questioning should follow. For instance, after the patient describes an interpersonal interaction with her husband, the therapist might follow-up by asking, “What happened with (or what changes did you notice in) your eating patterns after you talked with your husband?”

2. **Encouraging affect.** The focus of IPT throughout the therapeutic process involves affect evocation and exploration (Wilfley et al., 2000). This is particularly relevant for patients with EDs because problematic eating often serves to regulate negative affect. The IPT therapist should assist patients in: (1) acknowledging and accepting painful emotions, (2) being assertive in facilitating desired interpersonal changes, and (3) experiencing suppressed affect (Wilfley, 2008; Wilfley et al., 2000).

a. **Encourage acceptance of painful affects.** Patients with EDs are often emotionally constricted in situations when others would typically experience strong emotions. In the case of BN and BED, individuals use food to cope with negative affect. Therapy provides an arena to experience and express these feelings versus using food to cope with these feelings. As the feelings are expressed, it is important for the IPT therapist to validate and help the patient accept them (Wilfley, 2008).

b. **Teach the patient how to use affect in interpersonal relationships.** While the expression of strong feelings in the session is seen as an important starting point for much therapeutic work, the expression of feelings outside the session is not a goal in and of itself. The goal is to help the patient act more constructively (e.g., not binge eating or purging) in interpersonal relationships, and this may involve either expressing or suppressing affects, depending on the circumstances. A goal for the patient in IPT is to learn when her/his needs are met by expressing affect and when they are better met by suppressing affect. However, a primary goal is helping patients to identify, understand, and acknowledge their feelings whether or not they choose to verbalize them to others. The following is an example: “The therapist immediately noticed that Sara was silent and withdrawn at the beginning of the session. Initially, she denied any relationship between her nonverbal behavior and the therapist’s observation. The therapist was persistent and she eventually acknowledged that he was feeling hurt because her father had not acknowledged her son’s first birthday. She spent some time clarifying and expressing her feelings of anger and rejection with regard to her own relationship with her father. The issue that emerged in the session was “when do you stop wanting something from a parent that you can never get from them?” Even though she became aware of and expressed many painful feelings regarding her relationship with her father, Sara’s goal was not to go out and express these feelings to her father directly at this time. Instead, Sara and her therapist began to discuss how she can find herself more fulfilled and satisfied by working to make other choices in terms of who to turn to for support and care” (Wilfley, 2008).

c. **Help the patient experience suppressed affects.** Many who struggle with EDs are emotionally constricted in situations where strong emotions are normally felt. An example may be the patient who is unassertive and does not feel angry when their rights are violated. On the other hand, they may feel anger but may lack the courage to express it in an assertive manner. Sometimes patients will deny being upset, when it is clear that an upsetting interaction has just occurred. The therapists might say, “Although you said you were not upset, it appears to me that you have shut down since you talked about the situation with your husband.” In this way, the therapist will attempt to draw out affect when it is suppressed (Wilfley, 2008).
3. Clarification. Clarification is a useful technique that can: (1) increase the patient’s (p. 359) awareness about what she/he has actually communicated and (2) draw awareness to contradictions that may have occurred in the patient’s presentation of interactions or situations. An example might involve contradictions between the patient’s affect and speech: “While you were telling me how upset you are about your father, you had a smile on your face. What do you think that’s about?”

4. Communication analysis. The technique of communication analysis is used to: (1) identify potential communication difficulties that the patient may be experiencing and (2) assist the patient in modifying ineffective communication patterns. In using communication analysis, the therapist asks the patient to describe, in great detail, a recent interaction or argument with a significant other. As the patient describes the interactions, the therapist gathers information by using probes, such as the examples below (Mufson, Dorta, Moreau, & Weissman, 2004; Young & Mufson, 2003):

“How did you specifically say?”
“What did he/she say in response?”
“Then what happened?”
“How did you feel?”
“Do you think you might be able to tell him/her how you felt?”
“-thinking back to how the interaction turned out, did you send the message that you wanted to convey?”
“How do you think it made him/her feel?”

As part of communication analysis, the clinician then assists the patient in identifying ways in which the interaction could have gone differently; and how the different manifestations might impact the other person’s feelings and reactions. Therapeutic queries to facilitate this process include (Mufson et al., 2004; Young & Mufson, 2003):

“How do you think this interaction might have manifested differently?”
“What could have been said differently by either your or the other person?”
“How might it have changed the way that felt and/or the interaction itself?”

The objective is the clinician and patient to collaboratively work to identify difficulties in communication that may be impacting the process and outcome of the interaction and to find more effective strategies.

5. Use of the therapeutic relationship. The premise behind this technique is that all individuals have characteristic patterns of interacting with others. The technique is utilized by exploring the patient’s thoughts, feelings, expectations, and behavior in the therapeutic relationship and relating these to the patient’s characteristic way of behaving and/or feeling in other relationships. This technique is particularly relevant to and useful for patients with interpersonal deficits and interpersonal role disputes. Use of this technique offers the patient the opportunity to understand the nature of his/her difficulties in interacting with others and provides the patient with helpful feedback on his/her interactional style. The following is an example of using the therapeutic relationship.

Therapist: Joe, I know it was hard for you last week to talk about how your girlfriend does not understand that it is important for you to have time with your friends. Did you have a chance to discuss this with her over the past week?

Joe: No. I was really busy. She would have just argued with me if I brought it up anyway.

Therapist: As we have talked about before, I am wondering if you approach her about the topic differently this week, she might be more open to your point of view.

Joe: I doubt it. I am really busy this week, too.

Therapist: It feels to me like you do not want help with this situation, so I am feeling a little frustrated right now. I am wondering if other people in your life might feel the same way. What do you think?

In a nonjudgmental and straightforward manner, the therapist not only models clear communication with Joe, but also uses the therapeutic relationship to identify a potentially dysfunctional communication pattern.

3. The Termination Phase

By the end of the intermediate phase, patients are often acutely aware that treatment will soon be ending. The clinician should begin to discuss termination explicitly and address any anxiety the patient may be experiencing. In doing so, the patient should be prepared for emotions that may arise with termination, including grief related to the ending of treatment. At times, patients may deny any emotion with regard to the end of treatment and appear to have little reaction to termination. Nevertheless, the therapist should clearly address termination, as the (p. 360) patient may be unaware of or avoiding affect related to the end of treatment.

The termination phase typically lasts four to five sessions. During this phase, the patient should be encouraged to reflect on the progress that has been made during therapy—both within sessions and outside of the therapeutic milieu—and to outline goals for remaining work after the formal end of treatment. IPT does not assume that the work towards changes in interpersonal functioning is complete after the last session of the therapy. Rather, patients and therapist collaboratively summarize and draft the remaining work for the patient to continue outside of the therapeutic milieu. Patients are encouraged to identify early warning signs of relapse (e.g., binge eating, overeating and excessive dietary restriction, negative mood) and to prepare plans of action. Patients are reminded that ED symptoms tend to arise in times of interpersonal stress and are encouraged to view such symptoms as important early warning signals. The identification of potential strategies to cope with such situations is designed to increase the patient’s sense of competence and security. Nevertheless, it is also essential to assist patients in identifying warning signs and symptoms that may indicate the need for professional intervention in the future.

Use Of A Group

The group setting frequently provides an optimal modality for conducting IPT (Wiffley et al., 2000). Data from randomized trials suggest that both individual and group milieu of IPT are equally effective in the treatment of BN (Nevenon & Broberg, 2006) and BED (Wiffley et al., 2002) (Wiffley, Wilson, & Agras, 2008). After an individual session to conduct a thorough interpersonal inventory, the group is an ideal milieu to work on interpersonal skills with other patients struggling with similar eating problems. It also offers the therapist an opportunity to observe and identify characteristic interpersonal patterns with other individuals. Further, when another group member recognizes and verbally identifies a dysfunctional pattern of
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communication in a fellow patient, it can be powerful for the patient as well as the other group members (Wilfley et al., 2000). The following vignette provides an illustration from a group of adolescents with binge eating patterns.

**Therapist:** Sheila, you have done a great job of telling us what happened this week at school. It sounds like it was pretty upsetting when you saw Christine, your best friend, sitting with people who she knows you do not get along with. You recognized that it was not the right time to talk to her, so you just walked away and sat with someone else. But it is still understandably upsetting to you. The rest of the group has suggested that you tell Christine what is causing you to feel upset with her. Sheila, what might you say?

**Sheila:** I don't know. I guess I would say, “Christine, the other day you were sitting with Amy and Joyce. You know those girls talk about me behind my back. Why were you sitting with them?”

**Therapist:** That’s a good start. What do others think?

**Becca:** I guess I would have felt bad if I was Christine.

**Therapist:** How so?

**Becca:** Well, Christine might have felt accused of doing something wrong. I guess she might have felt as though she is not allowed to hang around with whomever she wants. I think that is how I might have taken it.

**Therapist:** Thanks, Becca. What do you think, Sheila?

**Sheila:** I did not mean to tell her that she cannot hang out with other people. I just wanted her to know that it made me feel bad that she was spending time with girls who are not nice to me.

**Therapist:** Does anyone have thoughts about how Sheila might better express what she really feels?

**Lisa:** I guess you could say, “Christine, I felt upset the other day when you were sitting with...” I can’t remember their names. “They talk about me behind my back. When you were sitting with them, I felt like you weren’t my friend.”

The group setting allows patients to experiment with different ways of communication within the safe confines of the group. Members can use the sessions to discuss problems they are having with their significant relationships and how these problems relate to their eating patterns. This often allows for patients to recognize that they are not alone in their difficulties, thereby helping to reduce feelings of isolation (Wilfley et al., 2000).

**Review of Outcome Studies and Relevant Empirical Literature**

**IPT for BN**

IPT has shown to be effective for the treatment of BN. Although cognitive behavioral therapy (CBT) (p. 361) is currently the most extensively researched, best-established treatment for BN (Wilson & Fairburn, 2001), IPT is the only psychological treatment for BN that has demonstrated long-term outcomes that are comparable to those of CBT (Wilson & Shafran, 2005). Currently, all controlled studies of IPT for BN have been compared to CBT for BN. In early studies, similar short- and long-term outcomes for binge eating reduction between CBT and IPT were reported (Fairburn et al., 1993, 1995). In a subsequent multisite study comparing CBT and IPT for BN, patients receiving CBT demonstrated higher rates of abstinence from binge eating and lower rates of purging in the short-term, post-treatment (Agras, Walsh, Fairburn, Wilson, & Kraemer, 2000). By 8- and 12-month follow-up, however, patients in CBT demonstrated maintenance or slight relapse while IPT participants experienced slight improvement such that rates of these behaviors were equivalent in both groups. The more impressive, immediate effect of CBT compared to IPT may be explained in part by a relative lack of focus on ED symptomatology in the research version of individual IPT for BN that was used in this study (Tanofsky-Kraff & Wilfley, 2010; Wilfley, Stein, & Welch, 2003). Despite the relatively slower response rates, IPT patients rated their treatment as more suitable and expected greater success than did CBT patients. Therefore, a potential strength of IPT may be that many patients with BN perceive the interpersonal focus of IPT as especially relevant to their ED and to their treatment needs, perhaps more so than a cognitive-behavioral focus on distortions related to weight and shape (Tanofsky-Kraft & Wilfley, 2010; Wilfley, Stein et al., 2003). Currently, IPT is considered an alternative to CBT for the treatment of BN (Wilson & Shafran, 2005). Although it has been recommended that therapists inform patients of the slower response time for improvements compared to CBT (Wilson, 2005), it is our contention that a lack of integration of BN symptoms with the interpersonal focus is likely responsible for the delayed response to IPT in the Oxford trial (Fairburn et al., 1993, 1995) and the less robust results in the multi-site study (Agras et al., 2000). Therefore, future research linking symptoms to interpersonal functioning is required.

An emerging literature has provided some insight into predictors of success with IPT for the treatment of EDs. In the multi-center trial conducted by Agras and colleagues (2000), a follow-up analysis found that while patients responded with higher abstinence rates when randomized to CBT as opposed to IPT, African American women showed greater reductions in binge episodes when treated with IPT compared to CBT (Chui, Safer, Bryson, Agras, & Wilson, 2007). Although further investigation is clearly necessary, it is possible that IPT may be especially appropriate for African American women with BN, which speaks to the need for further study of IPT with different racial and ethnic groups. Researchers from this same study also examined the impact of therapeutic alliance on patient expectation of improvement (Constantino, Arnow, Blasyer, & Agras, 2005). Expectation of improvement was positively associated with outcome for both CBT and IPT, emphasizing the important role of patient expectations in both treatments. Lastly, in a study of post-remission predictors of relapse in women with BN, the finding that worse psychosocial functioning was associated with a greater risk for relapse may support the rationale for IPT (Keel, Dorer, Franko, Jackson, & Herzog, 2005). Indeed, the authors suggested that their findings may partly help to explain the long-term effectiveness of IPT for BN.

**IPT for BED**

Based on the initial success of IPT in BN (Fairburn et al., 1991), IPT for BED was developed and tested in the early 1990s. Wilfley and colleagues first adapted IPT to a group format for adult patients with BED (Wilfley et al., 1993, 2000). During their work, they found that a number of patients presented with chronically unfulfilling relationships that were well-suited to be addressed in the group format. Therefore, new strategies were adapted to specifically address such interpersonal deficits. For example, in the current format of group IPT for BED, group members with interpersonal deficits are strongly encouraged to use the group as an interpersonal “laboratory”; therapists can observe, firsthand, patients interacting with one another, and patients can practice improved ways of communicating within the group. As described previously, this social milieu is designed to decrease social
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isolation, support the formation of new social relationships, and serve as a model for initiating and sustaining social relationships outside of the therapeutic context (Wilfley et al., 1998). In addition, self-stigmatization is common among patients with BED, and this stigmatization contributes to the maintenance of the disorder. By its very nature, group therapy offers a radically altered social environment for these individuals, who typically maintain shameful eating behaviors hidden from close others in their social network. By participating in a group with others (p. 362) suffering from the same types of psychiatric and physical issues, individuals with BED are offered a unique opportunity to feel both understood and accepted in IPT.

For the treatment of BED among adults, IPT has been demonstrated to be effective in randomized-controlled studies. CBT for BED has also been shown to have specific and robust treatment effects (Devlin et al., 2005; Grilo, Masheb, & Wilson, 2005; Kenardy, Mensch, Bowen, Green, & Walton, 2002; Nauta, Hopsers, Kok, & Jansen, 2000; Ricca et al., 2001; Telch, Agras, Risselte, Wilfley, & Kenardy, 1990; Wilfley et al., 1993). In two randomized trials comparing IPT with CBT, IPT had similar effects to CBT in the treatment and management of BED. The first study, comparing group CBT and IPT, revealed that both treatments were more effective than a wait-list control group at reducing binge eating and had equivalent, significant reductions in binge eating in both the short and long term (Wilfley et al., 1993). In a second substantially larger sample size, both CBT and IPT demonstrated equivalent short- and long-term efficacy in reducing binge eating and associated specific and general psychopathology, with approximately 60% of the patients remaining abstinent from binge eating at 1-year follow-up (Wilfley et al., 2002). In contrast to the literature on IPT for BN, the time course of almost all outcomes with IPT was identical to that of CBT and all participants in both groups significantly improved from baseline. In a follow-up analysis of treatment predictors for the 2002 study, patients with a greater extent of interpersonal problems at baseline and mid-treatment showed poorer treatment response to both treatments (Hilbert et al., 2007). An important caveat of this finding, however, is that not surprisingly, those individuals with greater interpersonal problems were also those who had more Axis I and Axis II psychiatric disorders and lower self-esteem than those with less severe problems. These individuals are likely in need of extended or extended treatment. Supporting this assertion, in IPT adapted for individuals with borderline personality disorder, many of whom presented with comorbid depression, Markowitz and colleagues suggest that extending IPT effectively improves the disorder (Markowitz et al., 2006). Notably, a preliminary examination of patients in this cohort at least 5 years post-treatment indicated that individuals in IPT maintained reductions in binge eating and disordered eating cognitions (Bishop, Stein, Hilbert, Swenson, & Wilfley, 2007). These data may suggest evidence for good maintenance of change for BED patients treated with IPT.

Results from a recently completed multi-site trial that compared individual IPT to behavioral weight loss treatment or CBT guided self-help (CBTgsh) for the treatment of BED points to the importance of making a clear connection between interpersonal problems and binge eating symptoms in the delivery of IPT. Similar to the 2002 trial of Wilfley et al. (Wilfley et al., 2002), in this multisite study, the clinic-based linked interpersonal functioning to disordered eating symptoms throughout the course of IPT. Findings from this study revealed that IPT was most acceptable to patients; the dropout rate was significantly lower in IPT compared to the other two interventions (Wilson et al., 2010). IPT and CBTgsh were significantly more effective than behavioral weight loss in eliminating binge eating after 2 years. Further, compared to the other two programs, IPT produced greater binge episode reductions for patients with low self-esteem and greater disordered eating behaviors and cognitions, while CBTgsh was generally effective for those with lower ED psychopathology. It is notable that in this trial, compared to the 2002 study (Hilbert et al., 2007; Wilfley et al., 2002), individuals with more psychopathology showed greater improvements in IPT than CBTgsh. This is in concert with Hilbert and colleagues’ follow-up data suggesting that greater disordered eating serves as a moderator in predicting poorer outcome in CBT (Hilbert et al., 2007).

In general, compared to Caucasian participants, individuals of other ethnic minorities demonstrated less retention in the multisite study (Wilson et al., 2010). Although there was no treatment by ethnicity effects in this regard, there was very low attrition for minority participants in IPT and very high dropout rates by minorities in CBT guided self-help. The small sample size of minority participants across sites precludes definitive conclusions. Nevertheless, this pattern is in concert with the finding that IPT was particularly helpful for African American participants in the previously described multi-site study for individuals with BN (Chui et al., 2007). It is possible that the personalized nature of IPT (e.g., problem areas and goals are developed based upon each individual’s social environment) is modifiable to, and thus particularly acceptable to, persons of various cultures and backgrounds.

A number of recommendations may be drawn from the research presented. It is possible, from a cost-effectiveness viewpoint, that CBTgsh could be (p. 363) considered the first-line treatment for the majority of individuals with BED, and that IPT is recommended for patients with low self-esteem and high ED psychopathology. Alternatively, IPT may be considered a first-line treatment for BED. This recommendation is based upon a number of factors: IPT has been shown to be effective across multiple research sites, is associated with high retention across different patient profiles (e.g., high negative affect, minority groups), and demonstrated superior outcomes to behavioral weight loss overall, and to CBTgsh among a subset of patients with high disordered eating psychopathology and low self-esteem. Therapists and patients should consider these alternatives when deciding the best approach to treating their disorder. Finally, behavioral weight loss should not be considered as a first choice when treating individuals with BED.

In summary, the literature suggests that IPT represents an efficacious treatment alternative to CBT for BED. If delivering IPT for BED in a group format, as with all group therapies, developing member cohesion is paramount to the achievement of treatment success. IPT for AN

In general, there are very few effective treatments for AN (Wilson, Grilo, & Vitousek, 2007). Although behavioral family therapy is considered the treatment of choice for adolescents with early onset of the disorder, these data are not especially informative when making recommendations for adults. With regard to IPT, there is a relative lack of research examining its utility for AN. Indeed, there have been no controlled studies demonstrating the efficacy of IPT for AN. To date, only one group has tested IPT for AN (McIntosh et al., 2005). Fifty-six women with AN were randomized to IPT, CBT, or a control comparison (non-specific, supportive clinical management). In contrast to the impressive effects of IPT for both BN and BED, this study found that IPT was associated with little improvement in AN symptoms compared to non-specific, supportive clinical management (McIntosh et al., 2005). Of the three therapies, non-specific, supportive clinical management was the most effective approach. Importantly, the authors posited that their findings may be a result of the relative lack of focus on ED symptoms in their adaptation of IPT (McIntosh, Bulk, McKenzie, Luty, & Jordan, 2000) and suggest that future studies implementing IPT for AN involve consistent connections between the interpersonal problem areas and the core symptoms of the disorder (McIntosh et al., 2005). Particularly given the ego syntonic nature of AN, the lack of focus on ED symptoms may have blunted IPT’s impact and avoided the essential work of the therapy (McIntosh et al., 2005). In summary, the short timeframe for the IPT work, a relative lack of symptom-focus, and the brief length of follow-up may have also contributed to the study outcome.

Given the importance of interpersonal functioning in etiological theories of AN (McIntosh et al., 2000), continued exploration of IPT’s utility in treatment of the disorder is clearly warranted. In particular, IPT for AN that includes a focus on ED symptoms as they relate to interpersonal problems is needed. It may be that for AN, IPT is optimally delivered in the context of other adjunctive treatments (e.g., pharmacological, nutritional), rather than as a “stand alone” treatment. Staging of treatment may also be important; IPT may be more suitable for the maintenance and relapse prevention stages of treatment than for the weight regain phase (Jacobs, Welch, & Wilfley, 2004).

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Choosing Treatment Modality

When determining the treatment approach for patients with EDs, the clinician and patient should together evaluate the advantages and disadvantages of utilizing IPT, CBT or another therapeutic approach, e.g., pharmacologic treatment. In making this decision, it is crucial for therapists to explore their own comfort level in terms of their expertise, theoretic knowledge, and propensity toward administering an interpersonally-focused treatment (Wilfley et al., 2000). IPT, like CBT, is a specialty treatment and should be administered only by trained practitioners. However, it has been argued that experienced therapists who have been trained in other treatment modalities tend to learn IPT quickly and are often able to implement IPT with a high degree of integrity despite minimal IPT-specific training (Birchall, 1999). Further, some therapists may consider IPT to be more acceptable than CBT. Although not specific solely to IPT, a naturalistic study of psychotherapy outcome in which 145 clinicians provided information about their ED patients found that compared to CBT, psychodynamic approaches that included IPT produced better global outcomes (Thompson-Brenner & Westen, 2005). Although there are limited data exploring the influence of therapist comfort on treatment outcome, it is possible that some clinicians are more comfortable administering treatments other than CBT, and this (p. 364) is reflected in the outcome of their work (Tanofsky-Kraft & Wilfley, 2010).

To date, there are more data in support of the efficacy of CBT for EDs. Although CBT has been shown to produce more rapid effects for BN, IPT produces equivalent outcomes over the long-term for adults with this disorder. IPT for BED appears to be equally as effective as CBT. Based upon the evolving literature, IPT may be well-suited for patients presenting with or without exacerbated difficulties in social functioning. Although greater problems were associated with poorer outcomes for both CBT and IPT in the Hilbert et al. (2007) study, the moderator effect that patients presenting with greater psychopathology seem to respond well to IPT in the more recent multi-site study (Wilson et al., 2010), suggest that IPT (or another specialized treatment such as CBT) may be well suited for individuals with a broad range of disordered eating and general psychopathology. Moreover, IPT may be enhanced for individuals with exacerbated psychological problems (Markowitz et al., 2006). It is also possible that IPT may be especially fitting for some minority groups, such as African Americans. Finally, it is possible that some patients may express discomfort or difficulties with elements of CBT (e.g., keeping food diaries); IPT should be considered for these patients as well (Tanofsky-Kraft & Wilfley, 2010).

IPT for the Prevention of Excessive Weight Gain

IPT has recently been developed for the prevention of excessive weight gain in adolescents who report loss of control eating (LOC) patterns. LOC refers to the sense that one cannot control what or how much one is eating, regardless of whether the reported amount of food consumed is unambiguously large (Tanofsky-Kraft, 2008). Common among youth, LOC eating is associated with distress and overweight (Tanofsky-Kraft, 2008), predicts excessive weight gain over time (Tanofsky-Kraft et al., 2010), and in theory, is believed to be a marker of risk for the development of subsequent clinical eating pathology such as BED. This adaptation makes use of both IPT for the prevention of obesity (IPT Adolescent Skills Training, IPT-AST) (Young, Mufson, & Davies, 2006) and group IPT for BED (Wilfley et al., 2000), and evolved from the outcome data of psychotherapy trials for the treatment of BED. An unexpected finding of IPT and most psychological treatments for BED has been that individuals with BED who cease to binge eat tend to maintain their body weight during and following treatment (Agras et al., 1995; Agras, Telch, Arom, Eldredge, & Marnell, 1997; Devlin et al., 2005; Wilfley et al., 1993, 2002). Therefore, it has been hypothesized that treatment of LOC eating among youth may reduce excessive weight gain and prevent full-syndrome EDs (Tanofsky-Kraft et al., 2007).

A number of factors suggest that IPT is particularly appropriate for the prevention of obesity in high-risk adolescents with binge or LOC eating patterns. Specifically, youth frequently use peer relationships as a crucial measure of self-evaluation (Mufson et al., 2004). A recent study revealed the importance of perceived social interactions and social standing on body weight gain over time (Lemeshow et al., 2008). In this prospective cohort study, adolescent girls who rated themselves lower on a subjective social standing scale were 69% more likely to gain more weight over time, compared to girls who rated themselves higher on the scale (Lemeshow et al., 2008). Further, overweight teens are more likely to experience negative feelings about themselves, particularly regarding their body shape and weight, compared to normal weight adolescents (Fallon et al., 2005; Schwimmer, Burwinkle, & Varni, 2003; Striegel-Moore, Silberstein, & Rodin, 1986), perhaps because of their elevated rates of appearance-related teasing, rejection, and social isolation (Strauss & Pollack, 2003). The social isolation that overweight teens report may be directly targeted by IPT. Finally, IPT is poised to increase social support, which has been demonstrated to improve weight maintenance in overweight adults (Wing & Jeffery, 1999) and children (Wilfley et al., 2007). Indeed, data suggest that low social problems predict better response to weight loss treatment in children (Wilfley et al., 2007).

IPT for the prevention of excessive weight gain (IPT-WG) for adolescents at high-risk for adult obesity, delivered in a group format, maintains the key components of traditional IPT: (1) a focus on interpersonal problem areas that are related to the target behavior (e.g., LOC eating in the present adaptation); (2) the use of the interpersonal inventory at the outset of treatment to identify interpersonal problems that are contributing to the targeted behavior; and (3) the three-staged structure of the intervention (initial, middle, and termination). The primary activities of IPT-WG are to provide psychoeducation about risk factors for excessive weight gain and to teach general skill-building to improve interpersonal problems. IPT-WG was founded on (p. 365) Young and Mufson’s IPT-AST (Young & Mufson, 2003) and group IPT for the treatment of BED in adulthood (Wilfley et al., 2000). IPT-WG differs from other adaptations in that it was developed specifically to address the particular needs of adolescent girls at high risk for adult obesity due to their current body mass index (BMI) percentile and report of LOC eating behaviors.

Based on IPT-AST, IPT-WG is presented to teenagers as “Teen Talk” in order to be non-stigmatizing. As designed by Young (Young & Mufson, 2003), this preventative adaptation of IPT focuses on psychoeducation, communication analysis and role playing. Specific interpersonal communications skills are taught, including “strike while the iron is cold,” “use ‘I’ statements,” “be specific” (when talking about a problem), and “put yourself in their shoes” (Young & Mufson, 2003). For IPT-WG, an additional skill, “what you don’t say speaks volumes,” has been added to teach adolescents how their body language has the ability to impact communication regardless of their words. During the interpersonal inventory, a “closeness circle” (Mufson et al., 2004) is used to identify the close relationships of the participant. Since IPT-WG is designed for adolescents ranging from age 12 to 17 years, sessions are geared toward the adolescents’ developmental level. For example, younger adolescents, who may be uncomfortable talking about themselves, may respond better to hypothetical situations and games, whereas older teenagers may more readily discuss their own interpersonal issues from the outset.

Based on IPT for BED, IPT-WG maintains focus throughout the program on linking negative affect to LOC eating, overeating, times when individuals eat in response to cues other than hunger, as well as over-concern about shape and weight. Further, a timeline of personal eating and weight-related problems and life events is discussed individually with participants prior to the group program. Similar to both programs, IPT-WG is delivered in a group format. IPT-WG is 12 weeks in duration, longer than IPT-AST (8 sessions), but shorter than group IPT for BED (typically 16–20 sessions). Similar to IPT-AST, group size is smaller than in IPT-BED (5 vs. 9 members), enabling therapists to keep adolescents engaged. As with group IPT for BED (Wilfley et al., 2000), participants meet individually with the therapist(s) for a brief mid-treatment meeting to discuss progress made on proposed therapeutic
goals, areas that are particularly challenging, and plans for continued work through the second half of the group.

The following case example of "Kay" briefly illustrates the presentation and treatment of an adolescent group participant. For sample cases of adults with EDs across diagnostic categories, we recommend referring to a book by Denise Wilfley and colleagues (Wilfley et al., 2000) as well as chapters on IPT for EDs (e.g., Jacobs et al., 2004; Wilfley, Stein et al., 2003).

Presentation: Kay is a 14-year-old African American girl with a BMI at the 85th percentile for her age and sex (Ogden et al., 2006). At intake, she reported engaging in an average of five to six episodes of LOC eating per month over the 3 months before intake. She specifically recalled engaging in two such episodes in the past month, both when alone and feeling “bored.” She reported feeling anger, distress, and regret following her LOC eating episodes. However, she was only able to connect her episodes to feelings of boredom. Kay endorsed some distress surrounding her shape and weight as well as feeling “fat” much of the time, but reported few attempts at dieting. She reported eating in response to a number of negative emotions, with a very strong desire to eat when feeling down, sad, stressed out, worried, or bored. Although she presented with few symptoms of depression, Kay did experience some sub-clinical threshold symptoms of anxiety. Although she reported feeling shy when meeting new people, she also endorsed having close friendships with peers in whom she could confide.

During her pre-treatment meeting, Kay reported a number of family stressors. In the months prior to intake, she had reluctantly returned to her mother’s home in the Midwest to attend the local middle school, after having attended boarding school for three years on the West Coast. She reported generally poor relationships with her parents, who had divorced when she was a baby. Kay indicated that because she and her mother were “a lot alike” and both very stubborn, they argued frequently. Most often, their arguments concerned Kay’s dislike of her stepfather, whom she referred to as obnoxious and racist. She reported that her mother no longer “thinks for herself,” but rather just agrees with her stepfather. Fights with her mother typically involved Kay saying something hurtful in the “heat of the moment” and/or walking away without resolution. Kay reported being left with emotions of both rage and guilt. During these times, she would often overeat and experience a lack of control over how much she was eating. Following the eating episode, she reported that her negative feelings eventually “went away.” (p. 366) Despite living in a nearby city, her biological father had little contact with her following her parents’ divorce. She had spoken with him one or two times per month for many years and up until intake. Kay reported feeling abandoned by her father and attributed his lack of availability to his own social anxiety. Nonetheless, she wished for a closer relationship, but never discussed her desire with him for fear that he would not be receptive.

Problem area: Kay’s IPT problem area was conceptualized as a role dispute. Moving home from boarding school—halfway across the country—decreased her independence and exacerbated the typical changes adolescents experience during developmentally appropriate individualization from their parents. Kay struggled with being unable to communicate successfully with either parent—or her stepfather—regarding her opinions and needs. In response to such disputes, Kay would experience negative affect and eat to cope with her emotions.

Goals: The therapists and Kay generated and agreed upon the following therapy goals for the 12-week intervention. The first goal was that Kay would work on gaining perspective to feel less frustrated with her parents and work on remaining calm in the moment. Second, she would aim to express her feelings of being let down and hurt by her father. If possible, she would consider discussing these feelings with him. Kay’s work in treatment would involve clarifying her role within the family, vis-à-vis her mother and stepfather, and learning how to negotiate and express herself with them in a more functional manner.

The IPT intervention is described next.

Initial phase: Kay was very engaged during the initial phase. She actively participated in the role play exercises and was open about her frustration with moving back home to live with her mother and stepfather. She also shared how she had a tendency to vacillate between speaking her mind and avoiding arguments by walking away, particularly with her mother. She reported overeating and feeling unable to stop, most often in response to avoiding arguments with her mother and feeling angry. Specifically, she shared that not only would her mother side with her stepfather during family arguments, but that her mother believed Kay was not intelligent. Her mother would often express her opinion about Kay’s intelligence with her stepfather and other friends. Kay was encouraged to role play a conversation with her mother in which she discussed her feelings. However, she remained skeptical that her mother would be responsive. While the therapists encouraged Kay to practice such a conversation in the group, they also recommended that she think about how to better tolerate her mother’s behavior if, in fact, she was unresponsive.

Middle phase: Kay spent more role playing conversations that she might have with both her mother and her father. The therapists encouraged Kay to initiate a discussion with her parents during which she would be specific about her frustrations while also trying to keep in mind an understanding of their perspectives. Initially, Kay was reluctant to follow up on this work. She was therefore encouraged to examine her pattern of anger and then avoidance, particularly with her mother. During the seventh session, Kay became frustrated with the therapists’ persistence and grew sullen and angered. She returned the next session to report that she was angry, confused and disappointed to have learned about some of her mother’s past behaviors of which Kay did not approve. The therapists encouraged Kay to take “a leap of faith” and try talking with her mother. After in-session practicing, Kay approached her mother and talked about her feelings in a calm manner. She was very pleased with her mother’s receptiveness to the discussion. By the end of the middle phase, Kay was also spending some time with her father. Moreover, she had opened up a dialogue with him regarding some of her feelings of disappointment with him. Much to her surprise, her father was more receptive to her self-expression than she had expected. Throughout this phase, Kay was frequently queried about her eating patterns. Initially, she noticed that that the frequency of her LOC eating episodes had decreased. Then, she became more cognizant of the times she would binge eat. For example, after finding out that an old friend was ill, she became very upset and was able to link her feelings to LOC eating.

Termination phase: Kay reported that not only was she sharing her feelings more often, but that she was overeating less frequently. She was supportive of other group members in taking on their own “leaps of faith” by describing how overwhelmed she felt before speaking with her parents, but how much better she felt after the conversations. By the final session, Kay was quite sad about the ending of the group. She reported that she was going to miss the support of the therapists and group members and realized that she still had a great deal of work to continue. The therapists focused upon the work she had accomplished and assured her that she had (p. 367) achieved the skills necessary to continue making improvements. Along with the therapists and the other members, Kay outlined the future work that she would continue after the groups ended. Specifically, she planned to continue dialogues with her mother and seek to develop a closer relationship with her father, with the recognition of his emotional limitations.

After treatment, Kay reported no longer experiencing episodes of LOC while eating. Moreover, her BMI percentile had decreased 5 percentage points to the 80th percentile for her age and sex (Ogden et al., 2006).

The courses of treatment for this individual, along with two other case examples, are illustrated in Table 20.4 (Tanofsky-Kraff et al., 2007).
In a pilot study testing IPT-WG compared to a standard health education program (Bravender, 2005), IPT-WG was shown to be both feasible and acceptable to adolescent girls (Tanofsky-Kraff in press). Further, more girls in IPT than health education experienced weight stabilization or weight loss, compared to weight gain, at the last measured observation. An adequately powered controlled trial is currently underway to determine the effectiveness of IPT-WG for the prevention of excess weight gain.

Future Directions for IPT in the Treatment of EDs

Several important areas require further study. An important next step is to determine whether IPT for EDs can be translated from specialty care centers to non-research clinical practice milieus. In an effort to continually improve IPT and broaden its utility, we propose other research directions in this section (Tanofsky-Kraff & Wilfley, 2010).

Enhancing IPT for BN and BED

As efforts to more frequently and consistently link ED symptoms to interpersonal functioning has evolved in the use of IPT for BED, clinical researchers involved in developing IPT for BN should also consider stressing this link during the delivery of IPT so that it offers the utmost potency. Since IPT does appear to have specific effects in BN and good long-term maintenance of change, it seems prudent to evaluate methods for improving its efficiency and clinical effectiveness. For instance, it may be that the slower and less potent effects observed in IPT as compared to CBT were due to the manner in which IPT was implemented. Specifically, in order to minimize procedural overlap with CBT, the research application of IPT for BN has not included an ongoing focus on making links between symptomatology and interpersonal functioning, which is in stark contrast to how IPT was developed and tested for depression. In future studies, the efficacy and efficiency of IPT may be enhanced by including a specific focus on the core symptoms of BN and their connection with interpersonal issues throughout the course of treatment. Such refinements of the content and delivery of IPT may further strengthen its usefulness in the treatment of BN.

IPT, in its current form, already seamlessly incorporates aspects of other therapeutic modalities. For example, the collaborative, interpersonal formulation of the ED symptoms during the interpersonal inventory is one of the ways in which IPT may resemble the behavior therapies more so than it does the supportive or psychodynamic therapies. Therefore, some aspects of CBT may enhance the efficacy of IPT (Tanofsky-Kraff & Wilfley, 2010). For example, IPT therapists might wish to encourage self-monitoring as a method for patients to become more aware of their negative affect surrounding ED symptoms. Such an approach is already being tested in other treatment modalities. Indeed, Fairburn and colleagues have found the inclusion of an interpersonal module useful when administering a recently modified version of CBT for EDs (Enhanced CBT for EDs), (Fairburn, 2008).

Adolescent and Child/Parent Adaptations

Given the robust efficacy of IPT for adolescents with depressive disorders, and the initial promise of IPT-WG, future research should involve additional adolescent adaptations (Tanofsky-Kraff & Wilfley, 2010). Adolescence is a key developmental period for cultivating social and interpersonal patterns, which may explain why adolescents appear to relate well to IPT. From its inception, Mufson and colleagues made important adolescent-relevant adaptations to the treatment (Mufson et al., 2004). For example, IPT for adolescent depression includes a parent component and the assignment of a "limited sick role," since youth are required to attend school and reducing their activities is likely to exacerbate their interpersonal difficulties. Given that this foundation has been established, the use of IPT for adolescents with BN and BED warrants investigation.

Utilizing IPT for younger children may also be a promising approach. A pilot study of family-based IPT for the treatment of depressive symptoms in 9- to 12-year-old children was found to be feasible (p. 368)
Interpersonal Psychotherapy for the Treatment of Eating Disorders

Table 20.2 Example of a Personal Historical-Timeline of a Patient with BED

<table>
<thead>
<tr>
<th>Example Participant</th>
<th>LOC Eating Precipitant(s)</th>
<th>Interpersonal Functioning</th>
<th>Problem Area</th>
<th>Goal</th>
<th>Initial Phase</th>
<th>Middle Phase</th>
<th>Termination Phase</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case 1</td>
<td>Sadness, stress, and worry</td>
<td>Repeated heated arguments with mother</td>
<td>Role dispute</td>
<td>Gain perspective to decrease frustration and remain calm when communicating with mother.</td>
<td>Sharing feelings of frustration with mother; in group role-play of discussions with mother.</td>
<td>Discuss resistance to speaking with mother; with group encouragement, began productive dialogues with mother.</td>
<td>Emphasis on improved communication skills; discussion of transferring use of skills to other close interpersonal relationships; gaining other outside supports</td>
</tr>
<tr>
<td>Case 2</td>
<td>Avoiding conflict and negative affect</td>
<td>Does not express negative feelings or discomfort with conflict in multiple relationships.</td>
<td>Interpersonal deficits</td>
<td>Become more comfortable with conflict and work on expressing feelings.</td>
<td>Discuss discomfort surrounding interactions involving conflict.</td>
<td>Practice sharing feelings via role-playing; encouraged to communicate. &lt; feelings with less tense relationship.</td>
<td>Emphasis on improved communication skills; focus on future generalizing of skills to several situations</td>
</tr>
<tr>
<td>Case 3</td>
<td>Boredom and frustration</td>
<td>Expresses emotions/needs to family (especially parents) in nonproductive manner.</td>
<td>Role dispute</td>
<td>Use more constructive communication to express self.</td>
<td>Communication analysis and in-group role-play of poor interactions</td>
<td>Continued role-playing specific situations and trying out discussions with siblings.</td>
<td>Emphasis on improved communication skills; focus on future sharing of deeper interpersonal conflicts with parents</td>
</tr>
</tbody>
</table>


Developing IPT for the Prevention of Eating and Weight-Related Problems

Given the increasingly high rates of obesity (Ogden et al., 2006), it may be reasonably posited that the increases in disordered eating will continue as well, considering that overweight is a significant risk factor for the development of eating pathology (Fairburn et al., 1997, 1998). Therefore, the use of IPT to prevent obesity and full-syndrome EDs should be explored, by targeting other behaviors that promote both conditions (Tanofsky-Kraff & Wilfley, 2010). Since not all overweight individuals report binge or LOC eating, reducing emotional eating and eating in the absence of hunger may also be suitable for IPT modalities. Recent studies suggest that LOC eating among youth is associated with eating in response to negative affect (Goossens, Braet, & Decaluwe, 2006), including anger and frustration, depression, and anxiety (Tanofsky-Kraff et al., 2007). In studies of adolescents, emotional eating is significantly correlated with constructs of disturbed eating (van Strien, 1996; van Strien, Engels, van Leeuwe, & Snoek, 2005) and symptoms of depression and anxiety (van Strien et al., 2005). Data also suggest that emotional eating may be associated with overweight among youth (Braet & van Strien, 1997) and overeating in cross-sectional structural models (van Strien et al., 2005). Considering that in controlled trials IPT for BED effectively reduces eating in response to negative affect in adults (Wilfley et al., 1993, 2002), preventive adaptations targeting emotional eating require investigation.

Eating in the absence of hunger has been associated with overweight (Moenes & Braet, 2007) and excessive weight gain over time (Shunk & Birch, 2004). Reported eating in the absence of hunger has been shown to be associated with LOC eating, emotional eating, and elevations in general psychopathology (Tanofsky-Kraff, Ranzenhofer et al., 2008). Of concern are data indicating that eating in the absence of hunger is a stable trait throughout youth (Birch, Fisher, & Davison, 2003; Fisher & Birch, 2002). Promising findings indicate that young children may be trained to better regulate food intake (Johnson, 2000), and a number of intervention studies targeting eating in the absence of hunger are currently underway. IPT may serve as a natural extension on this work; in particular, negative affect associated with interpersonal problems might be linked to eating in absence of hunger. Then, recognition of internal physiological hunger cues may be taught so that patients learn to differentiate true hunger from when they are already sated.
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Finally, there has been a growing interest in and awareness of the role that social and interpersonal factors may play in behavioral health problems (Glass & McAtee, 2006). For obesity in particular, moving away from focusing solely on individual behavioral changes (e.g., diet and exercise) and towards the greater social context has not been the norm. IPT may be particularly well-suited for developing new approaches for the prevention of obesity and EDs on a broader social level (National Institutes of Health [NIH], 2004; Tanofsky-Kraff & Wilfley, 2010).

Conclusion

Interpersonal psychotherapy for EDs is a focused, time-limited treatment that targets interpersonal problems associated with the onset and/or maintenance of the ED. The interpersonal focus is highly relevant to individuals with EDs, many of whom experience difficulties in interpersonal functioning. Depending on the individual's primary problem area, specific treatment strategies and goals are incorporated into the treatment plan. The primary problem area is determined by conducting a thorough interpersonal inventory, a unique aspect of IPT, and by devising an individualized interpersonal formulation for each patient. IPT has resulted in significant and well-maintained improvements for the treatment of BN and BED. Preliminary data support the utility of IPT for the prevention of excess weight gain in adolescent girls. Further investigation is required to determine whether IPT is suitable for and effective in the treatment of AN. Adaptations of IPT should be explored for adolescent populations and the treatment of other eating- and weight-related problems. Finally, an important next step is to disseminate IPT into routine clinical care settings.

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